INSURANCE

By EDGAR HUNTER WILSON*

The insurance cases decided during the survey period have reiterated and in some situations extended the application of established principles and have in a few instances announced new doctrines.

Cason v. Aetna Life Insurance Company[1] involved a problem of membership in an employee group life insurance program. In April 1951, Cason was in the employment of the city of Atlanta as a fireman. During that month he was injured and confined to his home. He never returned to work from the time of his injury until his death one year later. In January 1952, the city of Atlanta effected a group life insurance program for its fire department employees with the defendant company. The policy provided that the insurance would take effect on January 1, 1952: "Provided the Employee is then regularly performing the duties of his occupation." Cason was not performing his duties as a fireman on the date mention; nonetheless, the fire department sent an application to his home which he signed and returned to the defendant company through the fire department. The defendant company had no actual knowledge that Cason was not at work and did not discover this fact until after his death. The court of appeals held that the city of Atlanta was acting as agent for the insurance company in taking the application and issuing the certificate and therefore knowledge of the city was properly imputed to the company. Since the city had full knowledge of the facts when the certificate was issued the insurance company was estopped to deny the validity of the certificate.

The court in the course of its opinion pointed out that the position they were taking was the minority view. The great majority of cases hold just the opposite—that the employer is agent of the employee in effecting the insurance.[2] Further, the court recognized that their holding was inconsistent with the more recent Georgia cases[3] but indicated that they were following an earlier Georgia decision which

*Professor of Law, Walter F. George School of Law, Mercer University; LL.B. 1947, LL.M., 1948, S.J.D., 1954, Duke University School of Law; Member of Georgia and North Carolina Bars.

1. 91 Ga. App. 323, 85 S.E.2d 568 (1954).
2. VANCE, INSURANCE 1039 (1951).
3. Blaylock v. Prudential Insurance Co. of America, 84 Ga. App. 641, 67 S.E.2d 173 (1951); Lancaster v. Travelers Ins. Co., 54 Ga. App. 718, 189 S.E. 79 (1936); Thigpen v. Metropolitan Life Ins. Co., 54 Ga. App. 405, 195 S.E. 591 (1938).

did support their position.[4] The court found further support for its position in Code section 56-501 which reads, in part, as follows: "Any person who shall solicit in behalf of any insurance company . . . or who shall take or transmit, other than for himself, any application for insurance . . . shall be held agent of the company for which the act shall be done or risk shall be taken." Although the literal application of the statute supports the court's position, Chief Judge Felton's observation in his dissenting opinion to the effect that the statute was not applicable because it was aimed at situations where insurance companies were using subterfuge to keep from being responsible for their agents is a sounder interpretation.

As a practical matter insurance companies must rely on the employer for information about employees under group policies and therefore this decision puts insurance companies in a rather awkward position. However, the effect of the case can very probably be nullified in the future by placing a provision in the application stating that the employer acts as agent for the employee and not as agent of the insurance company.

In Faircloth v. Coleman[4a] the insured's wife claimed the proceeds of a life insurance policy on the ground that she was the properly designated beneficiary, and insured's mother claimed that the proceeds should be paid to her because insured had accomplished a change prior to his death. The company had paid the proceeds of the policy into the court and interpleaded the wife and mother. The policy provided: "With the consent of the company, the insured may from time to time while this policy is in force change the beneficiary by request to the Home Office, upon the company's prescribed form, accompanied by the policy, such change to take effect only upon endorsement thereon."

About three weeks prior to his death, insured had gone to the office of the local agent and stated that he had lost or misplaced the policy. He then executed the company's standard form requesting change of the beneficiary from his wife to his mother. This form was lost or misplaced before reaching the home office of the company. The court, in holding that the mother was entitled to the proceeds, stated that the provisions in the policy were for the protection of the company and where the company stands indifferently between the parties the court will weigh the equities of the parties. The opinion makes it clear that the mere intention of the insured to change the

4. Equitable Life Assurance Society v. Florence, 47 Ga. App. 711, 171 S.E. 317 (1933).
4a. 211 Ga. 356, 86 S.E.2d 107 (1955).

beneficiary is not enough, but he must do some overt act which clearly indicates his intention. The facts of this case constitute what should be the minimum requirements for treating the change of beneficiary as effective.

In three cases[5] the court of appeals affirmed judgments against insurance companies only on the condition that the awards of attorney's fees under Code section 56-706 be written off. This section provides that an amount for attorney's fees may be awarded on a finding that the insurance company was acting in bad faith in refusing to pay the claim. The court held that in these cases the evidence did not support findings of bad faith on the part of the companies. These cases indicate that the court will not allow Code section 56-706 to be applied so as to make the award of attorney's fees practically automatic any time an insurance company fails to pay a claim. In still another case[6] the majority of the court of appeals held that the question of the bad faith of the insurance company was properly a jury question, but Chief Judge Felton in a dissenting opinion stated that the facts would not support a finding that the company had acted in bad faith.

Probably the most interesting case decided during the survey period was that of *Lawler v. Life Ins. Co. of Georgia.*[7] Although the decision in the *Lawler* case involved a mixture of evidence law and insurance law, it is considered here in some detail because the case is important to the insurance law practitioner. In the *Lawler* case the plaintiff was seeking to recover as the beneficiary on a life insurance policy. The insurance company defended on the ground that the insured had obtained reinstatement of the policy by falsely and fraudulently answering material questions in the application for reinstatement. These questions related to whether insured had been attended by a physician or had a surgical operation within the past five years. In fact a substantial portion of the insured's stomach had been removed by surgical operation. At the trial of the case the doctor who had performed the operation testified as to time and nature of the surgery. The agent who took the application for reinstatement testified that insured answered the questions on the application, appeared to read the application and in the agent's presence attached his signature to it. The plaintiff introduced three witnesses who testified to the

5. Georgia Life and Health Ins. Co. v. Gammage, 91 Ga. App. 125, 85 S.E.2d 85 (1954); Guarantee Trust Life Ins. Co. v. Hill, 90 Ga. App. 287, 82 S.E.2d 885 (1954); Gulf Life Ins. Co. v. Moore, 90 Ga. App. 791, 84 S.E.2d 696 (1954).
6. Hanover Fire Ins. Co. v. Elrod, 91 Ga. App. 403, 85 S.E.2d 821 (1955).
7. 90 Ga. App. 481, 83 S.E.2d 281 (1954); rev'd 211 Ga. 246, 85 S.E.2d 1 (1954); rev'd 91 Ga. App. 443, 85 S.E.2d 814 (1955).

good character of the insured. The trial court directed a verdict for the insurance company.

On appeal the court of appeals reversed the trial court stating that evidence of good character alone was sufficient to rebut the uncontradicted evidence of a witness who impeached the conduct of the insured and thus the case should have gone to the jury. In the course of its opinion the court expressly overruled a contrary holding in *Henderson v. Jefferson Standard Life Ins. Co.*[8] The court of appeals relied heavily on the rule of criminal law to the effect that evidence of good character may alone, by creating a reasonable doubt, produce an acquittal.

On writ of certiorari the supreme court in a four to three decision reversed the court of appeals. The majority opinion of the supreme court stated that the criminal cases involving evidence of good character were not in point because the burden of proof on a plaintiff in a civil case was considerably less than the burden of proof imposed on the state in a criminal prosecution.

On remittitur to the court of appeals the case took a surprising turn. The court pointed out that they were still free to reverse the trial court for any reason not forclosed by the instructions and opinions of the supreme court. The court of appeals then stated that when the case was before them earlier they had not considered the question of whether the insurance company had proved that it had relied on the representations. Upon the consideration of the problem the court concluded that the insurance company had not shown reliance and reversed the trial court on that ground. Attention was called to the lack of showing of reliance in the dissenting opinion of the supreme court.

The plaintiff in *Gulf Life Ins. Co. v. Moore*[9] sought to recover on an industrial life policy. The company defended on the ground that the insured had made fraudulent misrepresentations regarding the state of her health in the application for the insurance. In affirming a judgment for the plaintiff the court of appeals stated that an incipient and fatal malady affecting the insured at the time she stated that she was in good health would not be grounds for avoiding the policy so long as it had not manifested itself or impaired the general healthfulness of the insured. Further, the court observed that a representation to avoid a policy must not only be false and material but fraudulently made as well. In this case there was evidence that the repre-

8. 39 Ga. App. 609, 147 S.E. 901 (1929).
9. 90 Ga. App. 791, 84 S.E.2d 696 (1954).

sentation had not been made at all and therefore the judgment for the plaintiff was properly affirmed.

Georgia Life and Health Ins. Co. v. Gammage[10] was an action by a beneficiary to recover the death benefits under a life and health insurance policy. The policy provided for the payment of certain hospital expenses and death benefits "resulting from accidental bodily injury, sickness, or disease originating after the Date of Issue, subject to the clause headed 'Exceptions'." One of the exceptions provided: "This policy does not cover (a) Sickness originating prior to 30 days after Date of Issue." The insurance company complained of the following charge given by the trial court: "I charge you that if the insured enjoyed such health and strength as to justify the reasonable belief that he was free from derangement of organic functions or free from symptoms calculated to cause reasonable apprehensions of such derangement and to ordinary appearance his health is such that he may, with ordinary safety, be insured upon ordinary terms, the requirement of good health is satisfied . . A policy applied for and accepted in good faith cannot be voided by proof that the malady which ultimately occasioned the death or sickness must have existed in some incipient form prior to issuance of the policy . . ." The court of appeals held that this charge was not in error, stating that to defeat recovery on such a policy by showing that death resulted from what was an unknown or incipient disease even though it had originated in a technical sense would be to defeat the bona fide expectations of the insured. Felton, C. J. and Gardner, P. J. dissented from this position on the ground that ". . . the appearance of the insured is immaterial, and such a policy cannot be said in every event to insure against a malady or disease which existed in an incipient form prior to issuance of the policy."

Three cases[11] reaffirmed the proposition that the provision in a life insurance policy that it will not take effect unless on date of issuance of the policy of the insured is in sound headth, refers to a change of health between the time of making the application and the issuance of the policy. In one of these cases[12] the insurance company argued that this rule was only applicable where there had been a medical examination. But the court held that the rule applied whether or not there had been a medical examination. Quillian, J. for the court said

10. 91 Ga. App. 125, 85 S.E.2d 85 (1954).
11. Family Fund Life Ins. Co. v. Rogers, 90 Ga. App. 278, 82 S.E.2d 870 (1954); National Life and Accident Ins. Co. v. Goolsby, 91 Ga. App. 361, 85 S.E.2d 611 (1955); National Life and Accident Ins. Co. v. Strickland, 91 Ga. App. 179, 85 S.E.2d 461 (1954).
12. National Life and Accident Ins. Co. v. Strickland, *supra*.

that the insurance companies were free to require an examination if they saw fit and whether the examination has been required or not the insurer has shown a willingness to insure on the basis of the insured's condition at the time application and therefore the sound health provision should only be applied to changes in health before the policy is issued.

In *National Life and Accident Ins. Co. v. Goolsby*[13] it was held that an insurance agent with authority to solicit and forward applications acts as agent of the company when he undertakes to prepare an application for a prospective insured. If the agent willfully inserts false answers to material questions, knowledge of the falsity will be imputed to the company. This same rule was held applicable in *Georgia Washington Life Ins. Co. v. Smith*[14] despite the fact that in case the soliciting agent was the daughter of the applicant for insurance.

The plaintiff sued for benefits under a disability insurance policy in *Franklin Life Ins. Co. v. Stiles*.[15] In upholding a judgment for the plaintiff the court held that the fact that the plaintiff had earned approximately $10,000 per year since his disability as compared to $15,000 a year prior thereto did not demand a finding that he was not permanently and totally disabled. There was evidence in this case that his earnings since disability were primarily from renewals of insurance policies sold prior to disability and from investments. The court observed that the provision in the policy related to loss of earning capacity and not necessarily loss of income. The test is whether insured can perform a substantial part of the duties of the occupation in which he was engaged at the time the policy was issued. Further, the court held that cardiac neurosis, caused by a heart disease and a resulting fear of heart trouble, constituted "disability by bodily injury or disease" within the provision of the policy.

Inter-Ocean Casualty Co. v. Scott[16] was an action to recover under a policy providing for the payment of benefits for death "resulting solely from bodily injuries effected directly and independently of all other causes through accidental means." The policy expressly excepted from its coverage death caused wholly or partly by bodily or mental infirmity. The insured, 68 years of age, received a leg fracture when struck by an automobile. While apparently recovering satisfactorily in a hospital he developed severe abdominal pains and it became

13. 91 Ga. App. 361, 85 S.E.2d 611 (1955).
14. 90 Ga. App. 459, 83 S.E.2d 302 (1954).
15. 90 Ga. App. 311, 82 S.E.2d 898 (1954).
16. 91 Ga. App. 311, 85 S.E.2d 452 (1954).

necessary to remove his gall bladder. He died about a week after the operation. Although varying in detail the medical testimony established that insured's injuries were not solely the cause of death but that the diseased gall bladder contributed to his death. The court noted that there was a conflict in the Georgia decisions. One case took the position that primary causes and secondary causes were of no concern in policies such as this. If the death was caused or contributed to wholly or partially by disease, there could be no recovery.[17] However, other cases[18] which this court followed have held that a disease must have caused the injury to which the insured succumbed in order to defeat recovery. The court said: ". . . the insured's beneficiary is not debarred from recovery because an injury caused solely by an accident, together with mental or physical infirmity, brought about the insured's death."

Maryland Casualty Co. v. U. S. Fidelity and Guaranty Co.[19] involved interpretation of the "omnibus" clause in an automobile liability policy. The named insured in the policy had given two parties permission to use his automobile and thus brought both of them within the protection of the policy for liability resulting from operation of the automobile. While one of the parties was driving the automobile and the other was riding as a passenger an accident occurred. The question presented in this case was whether the policy covered the driver's liability to the passenger since the passenger was also an "insured" under the policy. The court noted that this was a case of first impression in Georgia and that cases in other jurisdictions have refused to hold the insurance company liable under such circumstances. However, the court felt that the fact that the insured party was also an insured under the policy was not a sufficient reason for excusing the insurer from liability.

Other insurance decisions handed down during the survey period held as follows: An insurer's absolute refusal to pay a claim without giving insured an opportunity to submit further proof of loss and without raising objection to the form or sufficiency of the proof of loss, constitutes a waiver of the policy requirements regarding proof of loss,[20] an appraisal award pursuant to the provisions of a fire insurance policy may be set aside for mistake or fraud;[21] an exception

17. Harris v. Metropolitan Life Ins. Co., 66 Ga. App. 761, 19 S.E.2d 199 (1942).
18. Thornton v. Travelers Ins. Co., 116 Ga. 121, 42 S.E. 287 (1902); Hall v. General Accident Assur. Corp., 16 Ga. App. 66, 85 S.E. 600 (1915).
19. 91 Ga. App. 635, 86 S.E.2d 801 (1955).
20. Hanover Fire Ins. Co. of New York v. Scroggs, 90 Ga. App. 539, 83 S.E.2d 295 (1954).
21. Jordan v. General Ins. Co., 92 Ga. App. 77, 88 S.E.2d 198 (1955).

in a personal property floater policy to injury caused by "vermin" did not prevent recovery for injury caused by a squirrel;[22] in an action to recover under a policy insuring against damage done to an automobile by windstorm, the evidence supported a finding that the injury was caused by mechanical failure and not windstorm;[23] in an action to recover double indemnity for accidental death the evidence supported a finding that death resulted from accidental suffocation;[24] payment of an agreed sum by an insurance company to a garage at the direction of the insured and receipt of a release from insured constitutes a satisfaction of the insurance company's liability under a collision policy even though the garage fails properly to repair the vehicle.[25]

22. North British and Mercantile Ins. Co. v. Mercer, 211 Ga. 161, 84 S.E.2d 570 (1954).
23. McClelland v. Northwestern Fire and Marine Ins. Co., 91 Ga. App. 640, 86 S.E.2d 729 (1955).
24. Family Fund Life Ins. Co. v. Wiley, 91 Ga. App. 225, 85 S.E.2d 448 (1954).
25. Owens v. Service Fire Ins. Co. of New York, 90 Ga. App. 553, 83 S.E.2d 249 (1954).