INSURANCE

By J. EDWIN PEAVY*

Most of the cases decided during the survey period have reaffirmed established principles of law. It would be unusual, however, if in the course of a year the appellate courts should not extend some doctrine of law or deal with unusual or different fact situations which are of general interest to the bench and bar of the state handling insurance cases. The purpose of this article will be to point out in what areas and in what manner the law of insurance has grown during the survey period by judicial interpretation and to include at least a brief discussion of how the legislature has dealt with a branch of the law of insurance which has been to some extent the subject of criticism by the public.

The case of *Hayes v. National Life & Accident Insurance Company*,[1] an action on two insurance policies for accidental death benefits, presents an interesting fact situation with which the court deals. One policy contained an exclusion clause that no benefits were payable if death resulted "(iii) from injuries intentionally inflicted upon the insured by himself, or by any other person other than burglars or robbers, (iv) from participation in an assault or felony . . . ." The other policy provided that no benefits were payable if death results "(i) from self-destruction, while sane or insane . . ., (iv) from participation in an assault or felony." The insured sustained injuries in a shooting affray from which he died almost immediately.

There was evidence to the effect that: The shooting affray began when the insured's partner evicted a would be customer from their restaurant for drunkenness. The customer started firing into the restaurant and one of the bullets creased the chest of insured's partner. Immediately thereafter the partner took cover in a restroom, the customer ran from the restaurant and to its side out of sight from the front. The insured, upon being informed of what had happened, dashed into the restaurant and out the front door to his automobile to secure his pistol. There was a volley of shots exchanged between the insured and the customer during which the insured's partner ran to

*Member of the firm of Kopp and Peavy, Waycross; B.B.A., 1947 University of Georgia; A.B., 1948 Mercer University; L.L.B., 1949, Walter F. George School of Law, Mercer University; Member Georgia Bar Association.

1. 92 Ga. App. 540, 88 S.E.2d 750 (1955).

him out of the store and told him to get down behind the car. The insured died almost immediately after the firing ceased.

The trial court directed a verdict for defendant and overruled plaintiff's motion for a new trial. The court of appeals reversed the judgment of the lower court and held that the jury would be authorized to infer that the insured was not participating in an "assault or felony" within the meaning of the exclusion clauses of the policy; and also that the customer, who was firing while in a highly drunken condition, did not "intentionally" shoot the insured in that the customer's drunken condition rendered him incapable of "intentionally" shooting anyone, or that if he were capable of forming an intention to shoot, that the customer thought he was shooting at the insured's partner and not at the insured; and consequently that the insurance company, upon whom the burden rested to establish that the shooting was "intentional" within the meaning of the exclusion clause, had not carried such burden. .

In another accidental death case[2] it was alleged that the insured was in good health on the day of his death, that he felt ill because of nausea and called a doctor who injected 600,000 units of penicillin into the arm of insured, and that in less than five minutes after the injection the insured died. The action was to recover benefits of six insurance policies. Three of the policies provided for extra benefits for the death of the insured if resulting directly and independently of all other cause, from bodily injuries effected solely through external, violent and accidental means. One of the policies was an accident policy, which provided indemnity for death from accidental means: The other two policies were accident policies which provided for death due to bodily injury which was "effected accidentally and through external and violent means."

The trial court sustained a general demurrer and dismissed the petition, and plaintiff excepted to that judgment.

The court of appeals upheld the trial court in sustaining the demurrer as to the first four policies which provided benefits for death from "accidental means," and reversed the lower court in sustaining the general demurrer as to the two policies which provided indemnity for death due to bodily injury which was "effected accidentally and through external and violent means."

The appellate court in deciding the case borrowed some language

2. Johnson v. National Life & Accident Insurance Co., 92 Ga. App. 818, 90 S.E.2d 36 (1955).

from a previously decided case[3] and held that "for an injury to result from accidental means it must be the unexpected result of an unforeseen or unexpected act which was involuntarily and unintentionally done" and that "the act which preceded the injury itself must have been an accident." Since the injection, which was the act which preceded the injury, was done intentionally by the consent of the insured, the death did not result by accidental means.

The court drew a distinction between "accidental injuries" and "injuries resulting from accidental means", and held that "where an injury is unexpected but arises from a voluntary action it is an 'accidental injury'."

The court also rejected the contention that the deceased's death was caused by physical impairment which would bring the cause of death within one of the exceptions to the policy by holding that an idiosyncrasy consisting of hypersusceptibility to a harmless drug is not a "bodily infirmity" within meaning of an exception clause.

In *Guaranty Life Insurance Co. v. Brown*[4] the insuror defended on an action to recover on life policies by pleading that the policies had been obtained by fraud on the part of the beneficiary. The jury found for the plaintiff and granted her attorney fees and the statutory penalty[5] for bad faith. The defendant moved for a new trial on the general grounds which was overruled by the trial court. The appellate court in sustaining the lower court held that no evidence was introduced by the insurance company to substantiate the defense of fraud on the part of the beneficiary, and that the insurer's failure to introduce any evidence in support of their defense was sufficient basis for the jury to subject the insurer to the statutory penalty or failure to pay in bad faith.

The case of *Wooten v. Life Insurance Company of Georgia*[6] was an action upon a health and accident policy. The defendant tried to avoid payment for an illness, psychosis with epilepsy, occurring in 1953, upon the basis that the insured suffered from epilepsy at the time he took out the policy in 1951 and that the policy excluded payment for an illness existing prior to the date of the policy. Evidence was offered which would authorize the jury to find the insured had suffered from epileptic seizures for a number of years prior to the issuance of the policy including 1948. There was no evidence to con-

3. Continental Casualty Company v. Rucker, 50 Ga. App. 694, 179 S.E. 269, (1935).
4. 92 Ga. App. 847, 90 S.E.2d 97 (1955).
5. GA. CODE § 56-706 (1933).
6. 93 Ga. App. 665, 92 S.E.2d 567 (1956).

nect the seizures of the insured prior to the issuance of the policy to those seizures for which the claim was made. Judgment was rendered for the defendant and plaintiff moved for a new trial which was overruled. The appellate court held that it could not take judicial notice of the progress of the disease or the incidence of illness; and that in the absence of testimony connecting the seizures of 1948 and those from which the insured suffered in 1953, the defendant had failed to carry the burden of showing that the seizures were one and the same with no intervening period of freedom from disease, and that, therefore, a new trial should have been granted.

In a case[7] by the insured to recover benefits on a hospitalization policy, the appellate court held that where under the terms of the policy, the insured was authorized to assign benefits under the policy, and the insured had assigned such benefits to the hospital in which he was treated, but retained title to the policy, the insured could maintain an action against the insurer in his own name for the use of the hospital.

The court of appeals in another case[8] involving hospitalization insurance held that where a misrepresentation had been made in an application for insurance, which application is made a part of the policy, in order for the insurance company to avoid the policy, it is only necessary for it to show that the representation was false and that it was material. The test, the court said, "of the materiality of a misrepresentation is whether it influences the insurer in determining whether to accept the risk, and what premium to charge."

In *Bankers Fire & Marine Insurance Co. v. Hopkins*[9] the insurance company was defending an action upon a collision or upset clause of an automobile insurance policy. The defense was upon the basis that the policy was issued in the name of insured only, but that the automobile was in fact owned by the insured and his minor son. The policy contained several statements and provisions relative to the question presented by the defense, among which were statements: that the insured was the sole owner; that by acceptance of the policy the insured agreed the statements and the declarations were his agreements and that the policy was issued in reliance upon the truth of the representations; that the policy was void if the insured had misrepresented any material fact; and finally that notice to any agent or knowledge by any agent would not effect a waiver or estop the company from assert-

7. Reserve Life Insurance Co. v. Peavy, 94 Ga. App. 31, 93 S.E.2d 580 (1956).
8. General Assurance Corporation v. Roberts, 92 Ga. App. 844, 90 S.E.2d 70, (1955).
9. 93 Ga. App. 246, 91 S.E.2d 298 (1956).

ing any right. The corporate agent of the insurance company, through which the policy was issued, was fully informed at the time the application for the policy was made of the character of the insured's participation in the purchase of the automobile and the nature of the insured's interest therein. The court of appeals dealt summarily with the defense by holding that "where an insurance company places limitations upon the authority of its agents to enter into contracts of insurance and such limitations are contained only in the policy itself, such limitations are to be deemed as referring to matters occurring subsequent to the issuance of the policy, and do not apply to facts or conditions which were existing at the inception of the contract."

In *Hanover Fire Insurance Company of New York v. Scroggs*[10] the court held that a loss was not covered under an automobile theft policy where the agent of the insured automobile dealer entrusted custody of an auto to a supposed prospective purchaser for the purpose of trying it out, and the car was stolen or converted to the use of the supposed prospective purchaser. The policy contained an exclusion clause providing that coverage did not apply to loss "resulting from either the insured voluntarily parting with title and possession of any automobile if induced so to do by any fraudulent scheme, trick, device, false pretense, or from embezzlement, conversion, secreation, theft, larceny, robbery or pilferage committed by any person including any employee entrusted by the insured with either custody or possession of the automobile." The insurer contended that the words "voluntarily parting with both title and possession of any automobile" were applicable to that part of the provision which begins "or from embezzlement, conversion", etc. The court rejected this contention for the reason that the words "or from" separated the two parts of the sentence in the disjunctive, and because to so interpret it would render the last part of the provision meaningless.

In a case [11] involving automobile liability insurance the effective holding of the court of appeals was that a parol application for insurance is unenforceable. This case will be of considerable interest to any person who relies solely upon the insurance agent's parol promise that he is covered by insurance.

Johnson v. United States Fidelity & Guaranty Co.[12] involves some rather intricate reasoning by the court in holding an automobile liability carrier responsible to the insured sheriff for damages recovered

10. 92 Ga. App. 548, 88 S.E.2d 703 (1955).
11. Georgia Casualty & Surety Co. v. Hardrick, 211 Ga. 709, 88 S.E.2d 394 (1955).
12. 93 Ga. App. 336, 91 S.E.2d 779, (1956).

by the sheriff's deputy for injuries sustained while riding in the insured vehicle, which was involved in an accident with another vehicle, while the two officers were answering a call in connection with their official duties as peace officers. In order to arrive at the conclusion reached by the court it was necessary for the court to hold that the deputy sheriff was neither a servant nor employee of the sheriff within the exclusion clause of the insurance contract.

Cooper v. Glens Falls Indemnity Co.[13] involves a case against an automobile liability insurer by one who had recovered judgment against the insured in an action arising out of insured's operation of the covered vehicle. The insurer defended upon the basis that the insured had failed to forward to the insurance company, as required by the policy, the petition and process served upon them in the action in which the judgment was obtained against the insured. Facts were alleged for the purpose of obviating the necessity of forwarding the petition to the insurer to the effect that an adjuster for the insurer had stated to the insured that "it (the insurance company) was in complete charge of the matter, that the Pursers (the insured) had nothing to worry about in connection with the injury and that they need not further concern themselves about the matter." The court held that the insured had failed to comply with a condition precedent to insurer's liability and that the statement of the adjuster was nothing more than an assurance that they were covered by liability insurance and the insurance company would defend any action instigated against them.

Other insurance cases decided during the survey period held: An insurance company paying a judgment or claim cannot proceed in its own name against the joint tort-feasor, and hence cannot proceed against the joint tort-feasor's insurer, but that the action must be brought in the name of the insured;[14] a non-resident insurance company can be sued in a county where the company has an agent and place of doing business when the contract of insurance was made, although the company has abandoned its agency in the county and had no agent there at the time of the suit;[15] a person gratuitously performing a service for the owner of a service station during which he was injured resulting from the operator's negligence is not an employee of the operator so as to bring him within an exclusion

13. 93 Ga. App. 127, 91 S.E.2d 120 (1955).
14. Glens Falls Idemnity Company v. Canal Insurance Company, 93 Ga. App. 588, 92 S.E.2d 580 (1956).
15. Guarantee Trust Life Insurance Co. v. Ricker, 93 Ga. App. 554, 92 S.E.2d 323 (1956).

clause excepting liability for injuries sustained by employees.[16]

Most of the statutes passed during the survey period deal principally with matters of interest only to the insurance companies and are not of general interest to the average practitioner. Only one act is considered to be of sufficient interest to include here.

Act No. 344[17] deals with accident, sickness and hospitalization insurance, and is apparently designed to safeguard the public against unfair exercise by the insurer of what have formerly been contract rights but are now modified or denied the insurer by the act.

The act requires the insurance company issuing such policies to furnish applicants for such insurance a written outline of the major coverages and major exclusions of the policy for which application is made. The type of written outline can be controlled so that it will be understandable to the average layman by a requirement of the act that the form of the written outline must be approved by the Insurance Commissioner.

The provision of the act which lends real meaning to the above requirement is that if within ten days after the delivery of the sickness, accident or hospitalization policy, the insured returns the policy to the company or an authorized representative thereof and requests a refund, the company issuing such policy must refund all monies paid.

The act further provides that all such policies must contain or have attached thereto an incontestable clause as provided by the act.

Another rather sweeping provision of the act requires as a condition precedent to a company exercising a contract right of a policy renewal option or a cancellation option to first tender to the premium payor seventy-five percent of the difference between the monies paid in premiums and the claims benefits received, if the amount of premiums exceed the amount of claims received. This provision does not apply where such options are exercised within limitations past the insured's age sixty, or where there has been a change in occupation by the insured to an occupation generally classified by the company as uninsurable.

16. Griffin v. Hardware Mutual Insurance Co., 93 Ga. App. 801, 92 S.E.2d 871 (1956).
17. Ga. Laws 1956, p. 532.