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INSURANCE
By Maximilian A. Pock*

Again, as last year, the most important contribution to the law of insurance was not made by courts but by the legislature. Fourteen enactments attest to the prolificacy of the General Assembly, and of these, one promises to put Georgia in the forefront of the nation-wide movement to modernize and restructure the delivery system for lawyers' services—it is a comprehensive and well thought-out piece of legislation for the organization and policing of flexible prepaid legal services plans.

Of the 45 appellate cases decided during this survey period, only two involved issues of first impression, and only 28 warrant comment at this time. To provide continuity they will be discussed in accordance with the basic outline and subject matter headings employed in past years. Where certiorari has been denied or applied for but not disposed of during the survey period, this will be so indicated in the footnotes.

I. AGENTS AND BROKERS LIABILITY TO INSURED

In Wright Body Works, Inc. v. Columbus Interstate Insurance Agency1 the supreme court clarified the liability of intermediaries in the marketing of insurance and cut through some of the distortions caused by the misleading use of agency classifications. The insured contacted an insurance brokerage corporation and asked it to obtain a sufficient amount of business interruption insurance. The broker examined the insured's business records and procured two policies from different firms. These policies, although made available to the insured, were admittedly never examined by him. At the end of the two fiscal years subsequent to the issuance of the policies the insured provided the broker with additional audits to assure full coverage, but the broker initiated no modifications of the policies. When an insured fire loss occurred nearly three years after issuance of the policies it was discovered that the broker, while properly examining the annual audits to review coverage requirements, had negligently misread the policies and erroneously determined the amount of insurance needed to assure full coverage based on "gross profit" rather than "gross earnings" as specifically demanded by the policies. The resulting miscalculation had resulted in substantial underinsurance.

Is the broker liable to the insured in such circumstances? The supreme court answered this question in the affirmative and rejected the mechanistic rule that in every case where an insurance policy is issued and the insured is furnished with a copy of such policy he is charged with knowl-

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edge of its contents and *no recovery can ever be had* if the policy does not in fact provide the coverage contracted for. The ambit of this rule is at best limited to situations where the discrepancy between the policy and the coverage contracted for is readily apparent upon perusal and where the intermediary acts solely as an agent for the insurer throughout the entire transaction.

In the present case the insured had a contract with a broker obligating the latter to employ its expertise in reviewing the condition of the insured's business and maintaining coverage at a sufficient level. In undertaking to render this service the broker became the insured's agent and relieved its principal from the responsibility of effecting a minute examination of the policies. At any rate, the discrepancy was not readily apparent and hence not chargeable to the insured.

The court made several points which may help eliminate distortions in liability principles brought about by myopic unitary characterizations of intermediaries either as agents solely for the insured or as agents solely for the insurer. First, the fact that an intermediary is licensed as an "agent" or as a "broker" under the insurance code is irrelevant to a determination of liability because the controlling issue is the particular contractual or employment relationship between the parties and not the license held by the intermediary. Second, the fact that an intermediary has a pre-existing relationship with insurers placing it in the position of an underwriting agent for such insurers does not in and of itself prevent a dual agency. If such intermediary undertakes to select a particular insurer, or a particular coverage, or to render other services it becomes to this extent and in respect to this phase of the transaction an agent for the insured.

II. Application—Misrepresentation

Material misrepresentations in any application for life insurance are grounds for avoiding liability under the policy only if there is a showing that the insurer has reasonably relied upon them. An insurer which issues and delivers a policy after obtaining actual knowledge of an applicant's poor health and physical condition can hardly claim to have been misled. Recovery may thus be bottomed on the theory that the requisite element of reliance is missing, or that issuance constitutes a waiver of the known conditions. *Interstate Life & Accident Insurance Co. v. Merritt* illustrates that in order to invoke this principle a showing that the insurer had actual knowledge of the condition misrepresented is not necessary. There need only be a showing that the insurer had knowledge of facts reasonably

2. *Id.* at 270, 210 S.E.2d at 803.
3. *Id.* at 270, 210 S.E.2d at 803.
putting it on notice that the condition misrepresented might actually exist. In response to a question designed to elicit information on a list of specific diseases and ailments, an applicant for an industrial life policy disclosed that she had been suffering from arthritis and named the physician who had treated her. In response to an inquiry by the insurer’s medical director, the physician in question disclosed that he had treated the applicant for arthritis of the knees and hypertension. The insurer issued the policy and, after the insured’s death, declined to pay the claim on the ground that the answers made in the application had not correctly reflected the state of her health at that time since she had not revealed an advanced arteriosclerotic condition which progressed until the time of her death. The court held that the medical director of the insurer’s underwriting department actually knew that the applicant had been suffering from arthritis and hypertension, and as such, should have known that the applicant, shown on the application to be 69 years of age, might well suffer from complications attendant upon such ailments such as arteriosclerosis. Since the insurer was thus fairly apprised of the state of the insured’s health before issuance of the policy, its decision to issue the policy anyway amounted to a waiver of the very condition which it now seeks to assert as a defense.

III. Attorney’s Fees And Statutory Penalties

Blare developments under the code section on attorney’s fees and statutory penalties have inspired many a saturnine jeremiad in these pages. The statute was described as a dead letter for practical purposes. While not exactly an exercise in hyperbole, this characterization seems exaggerated when one uses the hindsight provided by recent cases. Thus in Interstate Life & Accident Insurance Co. v. Merritt a statutory penalty was assessed against an insurer which had issued industrial life insurance policies with full knowledge of the state of the applicant’s health and later, upon the trial, sought to avoid liability by showing that the applicant had made material misrepresentations regarding her medical history. The penalty was upheld because the insurer, having waived all known defenses when it issued the policies, simply had no valid defense left to resist payment of the claim. A jury finding of bad faith was thus authorized. In Interstate Life & Accident Insurance Co. v. Hopgood the insurer, faced with a claim under an accidental death policy, refused payment on the grounds that no such policy ever existed. At the trial, its district manager testified that there was no record of the policy and that no premiums had ever been paid on such policy. It was not until after the beneficiary on rebuttal produced the receipt book conclusively showing that premiums

had been paid on the policy that insurer’s counsel by leave of court communicated with the home office, discovered that premiums had in fact been paid, and stated so in open court. It was held that these facts provided a sufficient basis for the trial judge to find that the insurer had acted in bad faith. The court reiterated the principle that only probable cause for refusing payment will negative the imputation of bad faith, and that without such probable cause refusal will be at the insurer’s peril.

*Allstate Insurance Co. v. Harris* invites attention to certain inadequacies that inhere in the statute itself. Since liability for penalties and attorney’s fees runs only to the “holder of the policy,” insurers not constrained to use good faith in paying or negotiating settlements with third party beneficiaries, such as victims of automobile injuries who, having procured a judgment against the policy holder, now have a direct cause of action against the insurer. Since the statute seeks to curb chicanery, contumacy and stubborn litigiousness by insurers which, almost by definition, have more bargaining and staying power than their claimants, the statute should be redrafted so as to encompass not only immediate parties to the insurance contract, but also third party beneficiaries. This is particularly justified in regard to automobile liability insurance where party autonomy has been swept aside and third party rights have been mandated by statute.

IV. CANCELLATION

Insurance premium finance agreements commit the insured to pay to the premium finance company, usually, although not necessarily, a merchant in consumer goods or a lending institution financing consumer purchases, the amount advanced under the agreement to an insurer or insurance broker in payment of premiums. The agreement routinely contains a power of attorney enabling the premium finance company to cancel on behalf of the insured any insurance contract listed in the agreement in case the insured defaults on his payments. Since untimely cancellations, even though induced by the insured’s delinquencies, may have drastic consequences, the exercise of the power of attorney to cancel is closely policed by legislation. The premium finance company is required to give to the insured a 10 days notice in writing stating that it intends to cancel the insurance contract unless the default is cured within such 10-day period.

10. 133 Ga. App. 567, 211 S.E.2d 783 (1974). It may be noted in passing that Georgia still adheres to the notion that an insurer cannot be in bad faith if it defends on an issue which is one of first impression in this state. See Aetna Fire Underwriters Ins. Co. v. Crawley, 132 Ga. App. 181, 207 S.E.2d 666 (1974). Cases in other jurisdictions have occasionally held that an insurer may be found to be acting in bad faith if it “runs” a test case at the expense of an insured. If the insurer wants to settle a question to avoid future uncertainty it should arrange for a “friendly” suit and pay the insured’s litigation expenses. See, e.g., Seguin v. Continental Serv. Life & Health Ins. Co., 230 La. 533, 89 So.2d 113 (1956).

11. GA. CODE ANN. §84-5303(b) (Rev. 1970).

12. GA. CODE ANN. §84-5312(b) (Rev. 1970).
It is only after the expiration of such 10-day period that the company may cancel the insurance in the name of the insured by mailing to the insurer a notice of cancellation. Cancellation is then effected as though the insured himself had submitted the notice of cancellation.\(^\text{13}\)

*Garber v. American Mutual Fire Insurance Co.*\(^\text{14}\) is a remainder that such protective legislation has to be literally complied with. The insured had defaulted on his installment payments due under a loan contract and the premium finance company requested and obtained cancellation of the insured's automobile liability policy without complying with the 10-day notice period. It was held that the policy was not effectively cancelled. In order to establish termination of the contract the insurer would have been compelled to show (1) that it sent a cancellation notice of its own which satisfied the general statutory requirements for cancellations initiated by insurers\(^\text{15}\) or (2) that the premium finance company had sent a cancellation notice to the insured and had otherwise complied with statutory formalities.\(^\text{16}\) This the insurer could not do.

The net effect of this decision is that insurers collaborating with premium finance companies assume the risk that these companies either inadvertently or deliberately fail to adhere to the statutory cancellation procedure and thus exceed their authority to represent the insured in requesting cancellation. Since the statutory language is "read into" the power of attorney and supersedes conflicting provisions therein, the insurer cannot resort to such concepts as apparent authority or agency power to validate cancellation of the policy.

V. CONSTRUCTION AND DEFINITIONS

A. "Automobile Business"

Standard liability policies exclude non-owned automobiles "while maintained or used by any person while such person is employed or otherwise engaged in an automobile business." Such standard policies commonly define automobile business as "the business or occupation of selling, leasing, repairing, servicing, storing or parking of automobiles." Is a man who had been retired for about ten years from an automobile garage business he had formerly owned but who occasionally worked on cars of his friends in front of his house using equipment no more sophisticated than a little hand tool box and charging very little for his labors, engaged in the business or occupation of repairing automobiles? *State Farm Fire & Casualty Co. v. Thigpen*\(^\text{17}\) held that he was not. In the ordinary accepted sense working on fewer than one car per month hardly qualifies as a business,

\(^\text{13}\) *GA. CODE ANN.* §84-5312(c) (Rev. 1970).
\(^\text{15}\) *GA. CODE ANN.* §56-2430.1 (Rev. 1971).
\(^\text{16}\) *GA. CODE ANN.* §84-5312 (REV. 1970).
that is, as an undertaking engaged in with some regularity and for profit
and income, nor as an occupation, that is, as a vocation which principally
takes up one's time and implies an element of continuity or habitual prac-
tice.

B. "Automobile" And "Farm Type Tractor Or Other Equipment"

Did a bathtub which had four wheels, a steering mechanism, a motor
and brakes and which was designed for an annual "bathtub race," a kind
of motorized soap box derby held on the campus of a college, qualify as
an "automobile" within the intendment of that term as used in standard
family automobile policies? Horne v. Government Employees Insurance
Co." held that it did not. While the term automobile has a wide etymologi-
cal range in that it covers all manner of self-propelled vehicles designed
primarily for use on highways and streets and capable of carrying passen-
gers and loads, it does not connote all manner of motor vehicles. Its usual
and common signification would not, to name but one example, embrace
"motorcycle." While automobiles are necessarily motor vehicles, not all
motor-driven vehicles are necessarily automobiles.

Could coverage for this vehicular monstrosity be predicated on the lan-
guage of a clause excluding injuries "while occupying or through being
struck by a farm type tractor or other equipment designed for use prin-
cipally off public roads while not upon public roads"? Again the court con-
cluded that it could not. The vehicle was admittedly designed solely for a
race to be held on an elliptical roadway within the confines of the con-
trolled and guarded property of a college which was closed to ordinary
traffic on race days. If the contraption qualified as "other equipment," it
was designed "for use principally off public roads" and was involved in an
accident "while not upon public roads" and hence plainly within the com-
pass of the exclusion. If, on the other hand, it is argued that the race track
was a "public road," then the vehicle was designed from the very beginning
for use on public roads and would thus fail to qualify as "equipment
designed for use principally off public roads" under the exclusionary
clause.

C. "Loading And Unloading"

In Hodges Appliance Co. v. United States Fidelity & Guaranty Co." a
furniture company's truck had been insured as to certain hazards includ-
ing damages incurred in "loading and unloading." It was alleged that the
insured's agents had unloaded an upholstered sofa from the truck into a
floor surface in the buyers' home while the latter were away and that the
sofa caught on fire which spread to and consumed other property in the
room and damaged the building. It was held that the complaint stated a

cause of action. Notice pleading requires that whenever a motion to dismiss the complaint is made, the allegations in the complaint must be construed most favorably towards the party opposing the motion. Hence it had to be presumed that the floor furnace was lighted when the delivery was made and the sofa began to burn immediately after being placed on top of it. Absent a definition in the policy, it could not be said that "unloading" was completed until all of its phases were properly performed. The sofa here was not completely "unloaded" until it was placed in a location where it definitely and finally came to rest. Not necessarily the location which the buyers' interior decorator might ultimately have had in mind for it, but at least a location where it could have remained in relative safety. The court indicated that no cause of action would have been stated had the allegation disclosed that the fire had been the result of lighting the floor furnace after the sofa had been placed on top of it. Damage would thus not have been the product of "unloading" but of a supervening act of negligence.

D. "Motor Vehicle"

In Southern Guaranty Insurance Co. v. Duncan20 a youngster was injured as a result of a piece of metal being projected into his eye because of the alleged negligence of the homeowner while removing a steering wheel from an automobile on the insured's premises. The automobile had been adapted for use solely as a round track race car, had never been registered as a motor vehicle after its adaptation, and had always been carried to the various race tracks on a trailer. Was the automobile covered under a homeowner's policy which excluded coverage for any motor vehicles owned by the insured? The policy defined motor vehicle as "a land motor vehicle, trailer or semi-trailer designed for travel on public roads," but excluded equipment designed for use principally off public roads, if not subject to motor vehicle registration. (Emphasis added.) The court concluded that it was covered. The race car was not subject to registration and was designed for use principally off public roads. It was therefore not a motor vehicle within the sweep of the exclusion and thus as much within the coverage as a defective lawn mower or a loose shingle on the roof.

E. "Newly Acquired Automobile"

The standard "newly acquired automobile" clause is intended to meet the desire for maintaining coverage whenever insured automobile owners acquire other automobiles by way of replacement or addition during the life of their policies. As soon as the insured acquires ownership of such additional automobile his policy automatically extends coverage to it provided that the insured notifies his insurer within thirty days following the date of delivery of the automobile. Georgia Mutual Insurance Co. v. Crite-

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rion Insurance Co. adopted the regnant interpretation of this automatic coverage clause which characterizes the notice provision as a condition subsequent that must be satisfied in order to maintain coverage beyond the thirty-day period to the end of the policy term. Hence accidents occurring after the thirty-day period are covered only if the requisite notice was given during the thirty-day period. Accidents occurring during the thirty-day period are automatically covered irrespective of whether notice of acquisition is ever given. By the very terms of the policy it is the acquisition and not the notice of acquisition which affords an automatic and immediate extension of coverage for a thirty-day period. A failure to notify the insurer within this period terminates coverage as to future accidents but does not cut off liabilities incurred while coverage was in force.

F. "Temporary Substitute Automobile"

Standard automobile liability policies cover not only the described vehicle but also a temporary substitute automobile defined as "an automobile not owned by the named insured or his spouse if a resident of the same household, while temporarily used as a substitute for the described automobile when withdrawn from normal use because of its breakdown, repair, servicing loss or destruction." Fulcher v. Canal Insurance Co. held that a motor vehicle need not be a private passenger automobile to meet the policy definition of a temporary substitute vehicle; its use must not only be temporary but must also substitute for a described vehicle while such vehicle is immobilized or otherwise unavailable because of the listed conditions. A non-owned 1964 Ford truck which was often operated in the business of the insured and was customarily used to haul various appliances could hardly be said to have been but "temporarily" used nor, in the absence of a design or attempt to use the described and insured dump trucks, could it be said to have been used as a "substitute" for any of them. This is not to say, however, that an ordinary truck could not substitute for a dump truck or a passenger vehicle in an appropriate case.

VI. Cooperation Clauses

Liability policies contain as an important component of their cooperation provisions a clause which, making allowances for minor variations in language, requires that if a claim is made or a suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons or other process received by him or his representative. In Bituminous Casualty Corp. v. J.B. Forrest & Sons, Inc. 22 a suit was

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filed against the insured on August 21, 1973 but the summons were not forwarded to the insurer until January 11, 1974. The trial court held that the forwarding was timely in that the delay was due to the stay in bankruptcy granted as a result of a bankruptcy petition filed against the insured on August 22, 1973. The stay in bankruptcy prohibited any further action in the tort suit filed on the previous day and thus prevented any change in its status. It was held that the delay was unjustified as a matter of law. The stay in bankruptcy which kept the prior tort action in a state of suspended animation may well show that the insurer was not prejudiced by the delay. However, absence of prejudice is irrelevant where the policy casts its cooperation clauses in the form of *express conditions precedent* rather than in the form of promises by using language such as “no action shall lie against the company unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this policy.” The court conceded that the term “immediately” has not been given its literal meaning. Cases have found that forwarding was timely because the delay was justified by lack of knowledge by the insured, or because the insured had suffered some incapacitating injury or because of waiver conduct by the insurer. “Immediately” has thus been construed to mean with reasonable diligence and within a reasonable length of time in view of attending circumstances of each particular case. Here, however, the obligation to notify the insurer existed quite independently of pending bankruptcy proceedings. Furthermore, the fact that a bankruptcy petition was filed against the insured did not in any way prevent him or his attorney from forwarding the suit papers to the insurer or affect his capacity to do so.

Another perhaps even more important component of the cooperation “package” is the requirement that in case of an accident written notice shall be given by or on behalf of the insured to the company or any of its authorized agents as soon as practicable. Georgia Mutual Insurance Co. v. Criterion Insurance Co. illustrates that the term “practicable” is at least as flexible as the term “immediately” employed in other parts of the policy. The insureds had bought a Mustang automobile for use of their minor son which was involved in a collision soon after the purchase. The record disclosed that they failed to notify their liability carrier for nearly four months because they were ignorant of the fact that their policy automatically extended coverage to the Mustang as an additional automobile. When investigators for another insurer intimated to them that they might be covered under their own policy they promptly notified their insurer. It was held that this raised a material issue of fact and that the triers of fact

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might find that notification was made as soon as practicable. Hence the insurer was not entitled to a summary judgment.

VII. COVERAGE—EXCEPTIONS AND EXCLUSIONS

In Prudential Insurance Co. of America v. Howe\textsuperscript{28} the supreme court confirmed the old adage, apodictically asserted in many a decision,\textsuperscript{29} that insurance is a matter of contract, not sympathy. Airman Howe, a radar technician aboard a U.S. Air Force plane, died of asphyxia due to drowning and overexposure about seven hours after his plane had made an emergency landing in the Atlantic Ocean which had resulted in injuries to his leg and a slight bruise to his forehead. His life insurance policy excluded double indemnity coverage for death resulting "from travel or flight in or descent from any kind of aircraft, except as a passenger with no duties whatsoever aboard such aircraft while in flight." The court of appeals had held earlier that the exclusionary clause was inapplicable since death had legally resulted from drowning and not from the preceding crash.\textsuperscript{30} While the decision was based on the erroneous assumption of fact that the insured had left the airplane without suffering any injury and that he was in at least potential safety floating in his partially inflated life vest, there was language in the opinion indicating that the ruling would have been the same even if injuries had resulted from the crash itself because the lapse of several hours between the crash and the drowning broke the chain of causation and thus made the crash too remote to qualify as an efficient and proximate cause of death.

The supreme court reversed the court of appeals and held that the crash of the airplane was the legal cause of the insured’s death. To pretend that death, under the circumstances of the case, came from accidental drowning, would amount to a violent fiction which completely ignores the plain meaning of the word “resulting.” On a parity of reasoning the supreme court also stated emphatically that whenever injuries are sustained in the crash it could not be held as a matter of law that the passage of time alone, however extended, would break the chain of causation between the crash and the ensuing death by drowning.

\textit{Aetna Fire Underwriters Insurance Co. v. Crawley}\textsuperscript{31} is a case of first impression in this state. The insured’s home had sustained water damage as a result of a peculiar concatenation of circumstances. When a contractor built a house uphill from the insured’s home and made an excavation in order to tap on the sewage system of the new house to the main county sewer line, the excavation filled with water from surface drainage during

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\item[28.] 323 Ga. 1, 205 S.E.2d 263 (1974).
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a period of heavy rainfall. This water found its way into a nearby tap on the sewer line left open for future connection, creating tremendous pressure, and on reaching the lowest level at the insured's home entered through his appliance connections, at times shooting up some three feet into the air and causing considerable damage. The insured's homeowner's policy covered among the perils insured against "accidental discharge or overflow of water . . . from within a plumbing . . . system or from within a domestic appliance" but excepted losses "caused by, resulting from, contributed to or aggravated by . . . surface water . . . water which backs up through sewers or drains . . . water below the surface of the ground including that which exerts pressure on or flows, seeps or leaks through sidewalks, driveways, foundations, walls or floors."  

The court held that the damage was covered because the discharge of water from the insured's plumbing and appliance systems was not the result of any of the excepted causes. In order to reach this conclusion the court had to make three determinations: First, that the term "surface water" denotes only water flowing on the surface of the ground at the time it enters the home of the insured; Second, that the water did not back up from the insured's sewers and drains. Instead, it entered after collecting in an area remote from his premises and over which he had no control. This is to be contrasted with a situation where an immediate drain pipe is clogged by grease so that water backs up because it cannot be properly carried away. In such situation the exception would apply. Thirdly, the court had to determine that the water, although below the surface, did not flow or leak through the insured's sidewalks, foundations or walls but entered through a specific sewer pipe.

In *Tugalo Development Corp. v. Insurance Co. of North America* the insurer managed to avoid liability by falling back on the convolutions of a particularly poorly drafted exclusion. The insured marina owner leased a tractor-trailer and hired a driver to transport a houseboat to a boat show for display and sale. There was a collision in transit allegedly caused by the negligence of the driver which resulted in injuries to third parties. The policy provided protection for loss from property damage to insured boats, including the houseboat in question, which were owned or offered for sale by the marina. The policy also provided liability coverage for property damage and personal injury "if the assured shall by reason of his interest in any boat insured . . . become liable to pay . . . any . . . damages" but excluded "any liability incurred by the insured boat while it is ashore." (Can a boat incur liability?) The court held that the insured's liability did not arise "by reason of his interest in any boat" but because of vicarious liability for its servant's negligent operation of the tractor-trailer. Moreover, the liability plainly covered only boats afloat and not boats while in

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32. *Id.* at 182, 207 S.E.2d at 667-68 (emphasis added).
34. *Id.* at 497, 208 S.E.2d at 504-05.
transit ashore.

Health insurers naturally want to protect themselves against adverse selection and to avoid covering persons who seek to shift their medical expenses to insurers by buying policies on the advent of their hospitalization. One typical method for achieving this end is by a policy provision excluding coverage for charges for sickness, disease, or bodily injury which required medical care or treatment during the three months immediately preceding the effective date of the insurance. *Mutual Life Insurance Co. of New York v. Bishop* seems to limit the effectiveness of this exclusion at least as presently worded. The insured was covered under an employees group hospitalization insurance policy effective June 24, 1972. His wife, covered under the policy as a member of his family, was hospitalized only two days later for the removal of a cyst which later turned out to be a 22 pound ovarian tumor. During a routine physical examination prior thereto, on June 6, 1972, her physician found that her stomach was extended and suspected that this was due to one of two pathological causes. He told her to come in for testing on June 20, 1972. She underwent various tests on that date as a result of which a decision to operate was made. Did the examination on June 6 and the tests administered on June 20 constitute "medical care or treatment" within three months of the inception date so as to exclude coverage? The court held that it did not, explaining that "medical care or treatment" referred to something done in the application of the curative arts, whether by drugs or other therapy, with the end in view of alleviating a pathological condition. Preoperative visits for diagnostic and evaluation purposes did not fall into this category.

Whatever the salubrious effects of this decision upon insurance consumers who, after all, expect their coverage to commence on the effective day of the policy, its reasoning appears subject to serious objections. Given the fact that one is dealing not with coverage but with an exclusion from coverage, one may well agree that the phrase "medical care or treatment" should receive a narrow interpretation and not be extended to its maximum etymological range which would encompass all of the things performed by a physician on the body of the patient in the preparation for cure. Yet, how does one get around the import of the word "require" which was completely ignored by the majority opinion? Can one say that someone suffering from a malady who postpones appropriate treatment thereby proves that no treatment is "required"? If the insured actually suffers from a described disease and his condition indicates to him that medical attention is appropriate or needed if he is to have relief from his disease, then

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36. It should be noted that the policy involved in this case was not purchased with a view to having an insurer pay for a specific (and nearly certain) medical expense. The insured's husband had become a participant in a group plan by virtue of his employment.
“medical care or treatment” can be said to be “required” although it may not be technically dispensed to him at that time.

Regulatory statutes which compel certain coverages or require that the insurer include in its contracts provisions at least as favorable as the statutory model obviously supersede conflicting policy provisions; they are simply “read” into the policy. It is equally obvious that not all statutes regulating insurance effect policy content and party autonomy. Thus the Motor Vehicle Safety Responsibility Act requires the depositing of security as proof of ability to respond in damages for liability by the operator or owner of a motor vehicle involved in an accident so that the owner or operator will not have his driver’s license and registration certificate suspended. 39 One of the exceptions to this requirement is when the owner or operator “had in effect at the time of such accident an automobile liability policy with respect to the motor vehicle involved in such accident.” 40 This exception also provides with reference to liability insurance that the policy must provide coverage in certain minimum amounts. Fitzgerald v. Universal Underwriters Insurance Co. 41 held that the act does not require total coverage for any damages for which the insured might become liable. Its effect is simply that if an individual’s liability policy does cover his potential liability to “any person aggrieved after an accident” he does not have to post any security. It is only if he has no insurance at all, or if his policy does not cover the particular claim in question that he must prove financial responsibility. Hence an insurer under a motorcycle liability policy may freely exclude from coverage injuries to passengers of the vehicle. If an accident results in a liability claim by a passenger the act compels posting of security because the insured does not have the type of coverage which relieves him from this requirement. The statute regulates the activities of the insured and not those of the insurer and is not a mandate as to policy content.

VIII. DEATH BY ACCIDENTAL MEANS

“Double indemnity” benefits under life insurance policies and simple benefits under accident policies are recoverable only if death was caused solely by external, violent, and accidental means which arose solely and independently of other causes. Literally construed, this clause would mean that sudden death, although in and of itself viewed as an accident, is not covered unless it in turn is caused by an accident not contributed to by a preexisting infirmity or by other nonaccidental causes; in other words, the accident must be caused by an accident. It can easily be seen why this refined product of the draftsman’s art has been described as the most litigation-prone language found in insurance contracts. 42 One wonders if

42. E. Patterson, Essentials of Insurance Law 243 (2d ed. 1957).
this and cognate linguistic ventures are not infelicitous instances in which the legal profession has overserviced its clients. By drafting up to the edge of the possible and conscionable without leaving themselves a reasonable margin of safety, lawyers may have invited judicial nullification of their endeavors and spawned rules of misconstruction which ignore language and intent in order to give the consumer a "break." Georgia decisions have not followed the growing trend allowing recovery under this clause for all forms of sudden death even if produced by an intended act or nonaccidental cause just so long as the particular manner in which death occurred can be said to be an "accident" in common parlance. Nor have Georgia decisions followed the "strict constructionist" view of the clause, although they can be said to hover fairly close to it. In Life Insurance Co. of Georgia v. Thomas the insured was shown to have died from aspiration of food material, both digested and undigested, which had been regurgitated, clogging the windpipe causing asphyxiation. Although there was evidence that the insured might have died of natural causes or that death might have resulted from a malfunctioning of his epiglottis allowing him to draw the regurgitated food into his windpipe, a condition which might have been caused by his admittedly poor health, there was also evidence in the record allowing the jury to find that death was proximately caused by a sudden and accidental clogging of the windpipe by a foreign body (undigested food) which had not yet become a body fluid through natural digestive processes. This shows that conflicting expert evidence in the record may well save the day for beneficiaries even where juries are enjoined to subsume their findings under instructions hewing close to the "strict constructionist" point of view.

Also important, although occasionally overlooked, is the particular stage in the proceedings when the issue of coverage is raised and the particular procedural device that is employed to raise it. Thus in Allstate Insurance Co. v. Holcombe the insured died nine days after an automobile accident in which she was thrown into the steering column of her car when the steering wheel came off. The car crashed into a curb and went down a ravine. The insured complained that her stomach was hurt, went immediately home to bed, but refused medical ministrations or hospitalization saying, "No, I'm going to—I'm going to die right here." The next night her abdomen was considerably swollen. Eight days after the accident she started hemorrhaging severely and had to be taken to a hospital by ambulance. She died there a day later. The insurer moved for a summary judgment, largely based on a deposition taken from the family physician who had signed the death certificate ascribing death to an infarction of the

46. Id. at 112, 207 S.E.2d at 538.
small bowel and who had been familiar with the insured's condition for several years. Expertly calibrated questions finally led the physician to depose that death could have either been caused by severe arteriosclerosis from which the insured had been suffering for several years or from the impact with the steering column and that the chances were about "equal." Again the day was at least temporarily saved for the beneficiary when the court held that on a motion for summary judgment the burden was on the insurer to prove the negative, and to prove it by evidence that demands a finding in favor of the insurer. Since the evidence adduced did not show conclusively and as a matter of law that the infarction of the lower bowel of the deceased was not directly and independently of all other causes the result of the accidental injury received in the automobile a few days before her death, the insurer's motion for a summary judgment was overruled. Cases of this kind may, of course, be a pyrrhic victory for the insured because upon the trial the evidence will have to preponderate in favor of the insured. "Ify" testimony by the physician, which may cause the insurer to lose out during the summary judgment phase, may well lead either to a directed verdict or to a jury verdict in its favor.

Another asphyxiation case, Liberty National Life Insurance Co. v. Morris, involved a man hired to help run a moonshine liquor still who died the first day on his new job from aspiration caused by regurgitation of coffee-like grounds. The court clarified two points. First, that death can be classified as resulting from external means even though the foreign matter which becomes lodged in the windpipe after regurgitation emanates from inside the body. The court rejected as spurious the distinction made by some decisions which maintain that a seed from a ripe plum that becomes lodged in the windpipe on its way down and produces anoxia is an external means while a seed that is swallowed, goes into the stomach, and produces anoxia when accidentally regurgitated is not an external means because the seed is expelled from inside the body. Second, that the exception excluding from coverage death resulting from the insured's participating in an assault or felony becomes operative only upon proof of a causal connection between the felonious activity and death.

IX. LIMITATION IN POLICY—TIME FOR SUIT

Blanket accident and sickness policies "issued or delivered in this State" are required to contain certain provisions which are at least as favorable to policyholders as the standard provisions mandated by statute. The standard provision covering the "private" statute of limitations in policies compels insurers to offer as a minimum a clause stating that "no such action [on the policy] shall be brought after the expiration of three years

after the time written proof of loss is required to be furnished."49 Sloan v. Continental Casualty Co.49 held that this regulatory scheme is not applicable to a policy that is solicited, written, and delivered outside of this state and does not expressly contemplate coverage of the insured in this state when written. Hence a one year contractual limitation contained in such a policy will be given effect in this state if its incorporation is valid under the relevant law of the contract. This conclusion is not only predicated upon the specific statute itself50 but also upon the general conflict of laws principle injected into the Georgia Insurance Code.51

X. OTHER INSURANCE CLAUSES—PRIMARY AND EXCESS INSURANCE

State Farm Fire & Casualty Co. v. Holton52 again serves notice upon insurers that their ingenious attempts to sidestep the effect of pro rata liability clauses by drafting sublime “excess” and “escape” clauses may easily come to naught where two policies are present upon the same risk and both posture as excess insurance which becomes available only after the “other” policy is exhausted or which provide no coverage at all just because the “other” policy exists.

Mechanical decision formulas which designate one policy as “primary” and the other as “excess” on the basis of which policy was issued first or the directness of the primary tortfeasor’s relationship to a particular insurer are obviously arbitrary and often simply unworkable.53 It is better to recognize the situation for what it is—an irreconcilable conflict which is best resolved by ignoring the conflicting provisions and compelling the insurers to prorate. This is particularly the case when both excess provisions are highly specific and practically identical. Thus in Holton the tortfeasor was covered by his own homeowner’s policy while operating a non-owned motor boat and was also covered as a permittee under the omnibus clause of the boatowner’s policy. Both policies provided that under such circumstances they would only apply as excess insurance over the “other” insurance without regard to whether the insured was named or unnamed, or whether the watercraft was owned or non-owned. The court had no difficulty finding the provisions to be antithetical and disregarded them. It must be noted, however, that this decision leaves intact earlier holdings involving the usual conflict between the owner’s policy on a vehicle which covers the operator as an additional insured during permissive use, and the operator’s policy which covers him while using a non-owned

49. GA. CODE ANN. §56-3105(7) (Rev. 1971).
51. GA. CODE ANN. §56-3105 (Rev. 1971).
52. GA. CODE ANN. §56-302(4) (Rev. 1971).
54. For discussion of these approaches see Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch., 444 S.W.2d 583 (Tex. 1969).
vehicle. In such cases both policies usually provide for pro rata coverage under certain circumstances but extend excess coverage only in the event of user of a non-owned vehicle and the rule is that the owner's policy is charged with primary liability up to its policy limits, and the permittee's policy is liable only for excess coverage up to the amount of the judgment or its policy limit.

XI. UNINSURED MOTORIST COVERAGE

Wages v. State Farm Mutual Automobile Insurance Co. addresses an issue of first impression in this state—whether an insured co-defendant with sufficient liability insurance to satisfy judgments rendered in favor of the plaintiff jointly and severally against said insured co-defendant and an uninsured defendant, is entitled to contribution from the plaintiff's uninsured motorist carrier. The court held that the public policy of this state in enacting the uninsured motorist statute was to afford the public generally with the same protection in the form of a minimum uninsured motorist coverage that it would have had if the uninsured motorist had carried the same amount of coverage in the form of an automobile liability policy issued in his name. As such it followed that an insurer of a co-defendant in an automobile negligence suit has a right to seek pro rata contribution from the plaintiff's liability insurer which provides uninsured motorist coverage that it would have had if the uninsured motorist had carried the same amount of coverage in the form of an automobile liability policy issued in his name. As such it followed that an insurer of a co-defendant in an automobile negligence suit has a right to seek pro rata contribution from the plaintiff's liability insurer which provides uninsured motorist coverage in regard to an uninsured co-defendant. Contribution is thus as readily available as it would be if the "uninsured" co-defendant had in fact carried a liability policy containing the same limits as the uninsured motorist rider. Any other interpretation would in effect allow the uninsured motorist insurance carrier to limit the applicability of the uninsured motorist coverage to a sum which is in excess of other insurance coverage. Such position is untenable in light of Travelers Indemnity Co. v. Williams, which held that insurers could not evade the statutory mandate to pay the insured "all sums which he shall be legally entitled to recover as damages from the owner or operator of an insured motor vehicle" by the subterfuge of an excess or an escape clause.

State Farm Mutual Automobile Insurance Co. v. Jones involved a more direct attempt to avoid the reach of Travelers Indemnity. The insurer had

56. See, e.g., 115 Ga. App. at 802, 156 S.E.2d at 146.
61. 119 Ga. App. 414, 167 S.E.2d 174 (1969). Note that State Farm defended the uninsured motorist but was not a party to the action as such.
built an elaborate excess clause into its uninsured motorist rider. It con-
ceded that the excess clause would be void as to persons coming within the
definition of "insured" as contained in the uninsured motorist statute. At
the same time it contended ingeniously that the excess clause was valid
as to a person who, although actually an "insured" because of a sweeping
omnibus clause in the policy, did not meet the more narrow definition of
"insured" contained in the statute. The court held that since the policy
did not differentiate between different classes of insureds in its escape
clause, the word "insured" in that provision applied across the board to
all insureds, including those within protection of the uninsured motorist
statute. The escape clause was therefore in conflict with the statute and
on its face void.

The court indicated, however, that the result might be different if the
insurer had drafted its escape clause so narrowly as only to encompass only
persons falling outside the definition of "insured" contained in the unin-
sured motorist statute. This may well prompt another trip to the drawing
boards!

XII. Statutes

As suggested at the outset, the most significant piece of insurance legis-
lation emerging from the 1975 session of the General Assembly is the act
authorizing prepaid legal services plans. While too detailed for minute
expatiation in the context of this survey, the salient features can be
summed up as follows: First, the commissioner of insurance may license
any person, group, fraternal or benevolent organization, including but not
limited to insurers, corporations, partnerships, trusts, labor, craft or other
unions to "sponsor" (i.e., establish or operate) a prepaid legal services
plan in accordance with specified guidelines.

Second, licensed "sponsors" may enter into "subscription contracts"
with individuals, their employers, or with representatives of groups for
periods not exceeding one year. These contracts provide for rendition or
payment of certain legal services and must adhere to a prescribed statutory
model and be approved by the commissioner.

63. Ga. Code Ann. §56-407.1(b) (Rev. 1971), which states:
[T]he term "insured" means the named insured and, while resident of the same
household, the spouse of any such named insured, and relatives of either . . . and
any person who uses, with the consent of . . . the named insured, the motor vehicle
. . . and a guest in such motor vehicle . . .

64. The contract defined "insured" as "any person occupying an automobile not owned
by the named insured while being operated by the named insured." 133 Ga. App. at 920, 213
S.E.2d at 73.


66. Id. at 1270-72.

67. Id. at 1274-76.
Third, licensed "sponsors" may reinsure themselves by contracting with casualty insurance companies authorized to do business in this state to indemnify their subscribers in case their prepaid legal services plans fail to meet their obligations to provide or pay for the attorney's fees and court costs covered by the subscription contract. 68

Fourth, the commissioner of insurance is given extensive visitorial and monitoring powers. Underwriting rules and schedules for rates, premiums or membership fees charged to subscribers are subject to his approval. "Sponsors" are required to file comprehensive annual statistical reports which will generate actuarial and other information helpful in shaping the configuration of prepaid schemes in years to come. 69

Fifth, parameters for advertising and solicitation for prepaid legal services plans are carefully defined and the code's prohibitions of unfair trade practices are extended to "sponsors." 70

Georgia's foray into the terra incognita of no-fault insurance, the Motor Vehicle Accident Reparations Act enacted only in 1974, 71 became the subject of three amendments. First, optional coverages were somewhat increased, new definitions added, and present definitions refined. 72 Second, named insureds who have not previously responded to an offer to accept or reject the optional coverages required by the Act must be given another opportunity to do so. 73 Third, insurers cancelling the minimum insurance mandated by the Act are now required to notify the Department of Public Safety allowing it to initiate proper action in regard to obtaining proof of other insurance from the owner or effecting seizure of his operator's license and vehicle license tags. 74

FAIR (Fair Access to Insurance Requirements) Plans, the outgrowth of those frightful years when urban riots were threatening to become part of our daily routine, have been resuscitated. 75 These plans are designed to make essential property insurance available to all qualified applicants by requiring property insurers, as a condition of their authority to transact property insurance in this state, to become and remain members of underwriting associations which, subject to the approval of the commissioner, formulate and administer FAIR plans. The plans require that all member insurers participate proportionately in the underwriting, expenses, profits and losses. On meeting certain standards, FAIR plans make member insurers eligible for federal reinsurance.

The statute compelling insurers to give written notice of cancellation has been amended to allow policyholders more time to secure coverage from

68. Id. at 1276-77.
69. Id. at 1277, 1281-84.
70. Id. at 1278-79.
other insurers. If a policy has been in effect for at least 60 days and is cancelled for reasons other than failure to pay premiums, ordinary insurance consumers are now entitled to a 30-day notice. Holders of property and casualty policies on industrial or commercial concerns are entitled to a 15-day notice.

The Uninsured Motorist Statute was amended to provide a long-needed venue provision for "John Doe" actions. When action is instituted against an unknown defendant as "John Doe," the residence of such defendant shall be presumed to be in the county in which the accident causing injury or damages occurred, or in the county of residence of the plaintiff, at the election of the plaintiff in the action.

Other enactments during the current survey period are of a technical or administrative character. They include an amendment of the Premium Finance Company Act, the delineation standards for insurance holding company systems, the imposition of mandatory agreements for apportionment of certain casualty insurance, and the vesting of added powers in the office of commissioner of insurance, such as the power to license nonresident adjusters and to put insurers and their agents on probation and to impose monetary penalties.