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Insurance

by Maximilian A. Pock*

I. INTRODUCTION

A few prefatory and quite impressionistic observations seem warranted. The annual stream of substantive "insurance" cases, and cases that have an "insurance" integument, continues unabated. Georgia has definitely joined the ranks of "tastemaker" states that have a decided influence on the evolution of insurance law, as is evidenced by the frequent appearance of Georgia decisions in our leading law school casebooks.

The new user-friendly "easy reading" policies are surfacing in ever increasing numbers in our appellate jurisprudence. Whatever their intrinsic merits, these policies seem to absorb more judge-time because they do not, as yet, travel with the baggage of decades of judicial gloss that has refined the meaning of old-line policies. Cases in which claimants demand their attorney fees and statutory penalties,¹ punitive damages, and damages for infliction of mental distress appear on the increase. Since these cases tend not to "new-model," but to apply conventional principles to factual nuances, they do not invite discussion within the narrow editorial confines of this survey.

II. CANCELLATION AND NONRENEWAL

The Georgia Code defines the "renewal" of an automobile policy as the "issuance and delivery . . . of a policy superseding *at the end of the policy* period a policy previously issued and delivered by the same insurer."² Can a policy that commences at some time after the expiration of the old policy qualify as a renewal policy, or is it a new policy that the insurer can only terminate upon giving the thirty-days cancellation notice pre-

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1. O.C.G.A. § 33-4-6 (1992).

2. *Id.* § 33-24-45 (Supp. 1992) (emphasis added).

scribed by statute?³ The court of appeals thought that a coverage gap of two days automatically turns such policy into a new policy, whatever its label.⁴ The supreme court, in *Progressive Preferred Insurance Co. v. Brown*,⁵ reversed the court of appeals and held that such gap "does not preclude the second policy from being a renewal contract. A renewal policy can begin on another date by agreement of the parties to the contract."⁶ Whether the parties intended a renewal policy or a new policy thus depends on the circumstances. In the case before the court the circumstances clearly pointed to a renewal policy: the insurer had indicated in a paper styled as a "Renewal Notice" that it was willing to issue an identical policy if it received payment by the renewal date; the insured mailed his premium check by the renewal date and enclosed the bottom portion of the "Renewal Notice"; finally, the declaration page listed the same policy number as the "Renewal Notice."⁷ It followed that the insurer did not have to comply with the statutory cancellation procedure for new policies. It could simply declare the coverage forfeited on a showing that the insured never accepted the insurer's offer. This raised another issue, which the court of appeals did not have to address under its view of the case: Can a check that is dishonored and returned for insufficient funds qualify as "payment" of the premium and thus constitute a timely acceptance of the renewal offer? The court held that checks are only taken as conditional payment unless the parties agree otherwise.⁸ There is no payment if the check is dishonored. Moreover, the fact that the insurer retains the check after dishonor, and unsuccessfully presents it a second time for payment does not waive its right to void the policy.⁹ This is premised on the rationale that the insurer "should not suffer a penalty for giving the insured a second chance to have the payment collected before voiding the policy."¹⁰

3. *Id.* § 33-24-44 (1990).

4. *Brown v. Progressive Preferred Ins. Co.*, 198 Ga. App. 599, 402 S.E.2d 303 (1991), *rev'd*, 261 Ga. 837, 413 S.E.2d 430 (1992).

5. 261 Ga. 837, 413 S.E.2d 430 (1992).

6. *Id.* at 839, 413 S.E.2d at 432.

7. The policy numbers differed only in regard to the last digit, which was apparently intended to indicate that policies were issued in sequence. *Id.* at 838, 413 S.E.2d at 431.

8. *Id.* at 840, 413 S.E.2d at 433.

9. *Id.*

10. *Id.* The court distinguished the seemingly contrary holding in *Veal v. Security Mut. Life Ins. Co.*, 6 Ga. App. 721, 65 S.E. 714 (1909), partially on the grounds that the policy in *Veal*, unlike the renewal offer in the present case, "contained no provision making the insured's failure to pay the check a ground of forfeiture." 261 Ga. at 839, 413 S.E.2d at 432.

III. COOPERATION CLAUSES

Insurance policies abound with cooperation clauses. Whether they are framed as duties or come well armed with shield and buckler as express conditions precedent, such clauses have the capacity to put paid to otherwise meritorious claims. However, since courts abhor forfeitures, their practical impact is often softened by judge-made rules that content themselves with "substantial compliance" or insist that the insurer be "prejudiced" by their violation.

The case of *Titan Indemnity Co. v. Hall County*¹¹ serves as a paradigm to support this generalization. Two motorists were killed when their car "crashed through a wooden guardrail on a county-maintained bridge."¹² The county administrator did not suspect that the accident might result in a claim against the county despite the sheriff's report that, arguably, indicated it might. The survivors filed a wrongful death action against the county nineteen months after the accident and thirteen months after the insurer obtained notice of its occurrence from an unrelated third party.¹³ Was this a violation of the "prompt" notification requirement in the policy?

It happened that shortly after the accident the county administrator had called the agent who had sold the liability policy at issue. During this conversation, which concerned unrelated business, the topic turned to the county's plans for the replacement of the bridge, and the administrator mentioned "that there had recently been an automobile accident on the bridge in which two people had died."¹⁴ The court explained that the policy only required the insured to give prompt notice of "an occurrence which *may* result in a claim"¹⁵ and not "notice that a claim *will be made* against the insurer."¹⁶ Whether the administrator's communication to the selling agent was sufficient to amount to such a notice was an issue for the triers of fact and thus resisted disposition by summary judgment in favor of the insurer.¹⁷

The policy in *Titan* also informed the insured that "[a]ny error, misstatement or mistake in information given by you to us will not invalidate the insurance provided by this policy unless it was intentional. However, we are entitled to premium based upon the correct information."¹⁸ The insured contended that its failure to give prompt notice was, at any rate,

11. 202 Ga. App. 38, 413 S.E.2d 213 (1991).

12. *Id.* at 38, 413 S.E.2d at 213.

13. *Id.*, 413 S.E.2d at 214.

14. *Id.*

15. *Id.* at 39, 413 S.E.2d at 214 (emphasis added).

16. *Id.* at 40, 413 S.E.2d at 215 (emphasis added).

17. *Id.*

18. *Id.* at 39, 413 S.E.2d at 214.

excused because it was unintentional. The court disagreed.¹⁹ Read *in pari materia* the "Unintentional Errors and Omissions" clause concerned itself solely with the failure to report information relating to the risk before issuance of the policy and not with the failure to report information relating to accidents after its issuance. Any other reading would deprive the second sentence, "[h]owever, we are entitled to premium based upon the correct information," of its obviously intended meaning.²⁰

Benevolent construction does, however, have its limits. In *Brazil v. Government Employees Insurance Co.*,²¹ the insured waited thirty-eight months before notifying the insurer that he sustained an injury in an automobile accident that his policy clearly covered. He offered no excuses.²² The court could not but hold that the egregious delay under a policy that required notice "[a]s soon as possible" was unreasonable *as a matter of law*.²³

The Georgia Code mandates that automobile liability policies contain a corporation clause requiring the insured "to send his insurer, *as soon as practicable* after the receipt thereof, a copy of every summons or other process relating to the coverage under the policy."²⁴ This clause is not framed as an express forfeiture condition but only as a contractual obligation. Hence, its breach forfeits the insured's coverage and the right to be defended by the insurer only "if *prejudicial* to the insurer."²⁵

What is the posture of a liability insurer which can prove not only that it received no notification of the filing of the suit against its insured, but also that it received no notification regarding the status of the suit until entry of a final default judgment? Does a showing of prejudice demand that the insurer prove that it had assertable defenses, which can no longer be interposed because it lost its statutory basis for setting aside the default judgment?²⁶

In *Champion v. Southern General Insurance Co.*,²⁷ the court of appeals held that in these circumstances the insurer "carried its burden of showing prejudice by proving that default judgment had been entered against its insured before it received any notification of the suit."²⁸ The insurer

19. *Id.*

20. *Id.*

21. 199 Ga. App. 343, 404 S.E.2d 807 (1991).

22. *Id.* at 343, 404 S.E.2d at 808.

23. *Id.* at 344, 404 S.E.2d at 809.

24. O.C.G.A. § 33-7-15(a) (1992) (emphasis added).

25. *Id.* § 33-7-15(b) (emphasis added).

26. Except for the limited instances of jurisdictional errors and fraud, accident or mistake, challenges to default judgments can only be based on nonamendable defects appearing on the face of the record or the pleadings. *Id.* § 9-11-60 (Supp. 1992).

27. 198 Ga. App. 129, 401 S.E.2d 36 (1991).

28. *Id.* at 132, 401 S.E.2d at 39.

did not have to show precisely how its defense of the insured was prejudiced.²⁹ A delay of this kind is obviously prejudicial because it deprives the insurer of "an opportunity to investigate and marshal defenses at a time when events are fresh in the witnesses' recollections."³⁰ Normally, uncontroverted evidence that the insurer had not received notification of the suit until entry of judgment would, unalloyed by other facts, entitle the insurer to summary judgment as a matter of law.

In the case *sub judice*, however, the record disclosed that the insurer had admitted receiving from the insured's attorney an offer to reopen the default judgment. This permitted the inference that acceptance of the offer and the resultant opportunity to conduct a trial de novo would have negated any prejudice the insurer might have suffered because of the late notification. Since the insurer adduced no evidence to rebut this inference, there remained a genuine issue of fact that precluded disposition by summary judgment.³¹

First party property coverages in automobile policies typically require the insured to "[t]ake reasonable steps to protect 'your covered auto' from further loss,"³² or to "protect the automobile [in the event of loss]."³³ What is the precise scope of such a clause? In *Georgia Farm Bureau Mutual Insurance Co. v. Murphy*,³⁴ the insured lost control of her Taurus, which left the road and careened into a pecan tree. Although the impact had flattened a front tire, she managed to drive the car back on the road. After eleven miles a rear wheel assembly fell off. Undaunted, she continued, and after another twenty miles her odyssey finally came to an end when the car caught on fire.³⁵ Despite some conflict in the evidence, the court concluded that the jury was justified in finding that the impact had so warped the car's unitized body that it was "totalled," in the sense of being "rendered valueless by the collision with the tree."³⁶ At this point the insurer's obligation to pay for the precollision value of the car became fixed, and the insured's duty to protect the car from further damage ceased.³⁷

29. *Id.* at 131, 401 S.E.2d at 39.

30. *Id.*, 401 S.E.2d at 38 (quoting *Berryhill v. State Farm Fire Ins. Co.*, 174 Ga. App. 97, 99, 329 S.E.2d 189, 191 (1985)).

31. *Id.* at 132, 401 S.E.2d at 39.

32. See, e.g., ALLIANCE OF AMERICAN INSURERS, 1991 POLICY KIT FOR STUDENTS OF INSURANCE 10 (1991) [hereinafter KIT].

33. See, e.g., 1963 Family Combination Automobile Policy, in ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW 1120 app. H(1) (1988).

34. 201 Ga. App. 676, 411 S.E.2d 791 (1991).

35. *Id.* at 676-77, 411 S.E.2d at 792.

36. *Id.* at 679, 411 S.E.2d at 794.

37. *Id.* at 680, 411 S.E.2d at 794.

Arguably, this conclusion, while correct within the factual matrix of the case,³⁸ may be too broad. "Totalled" is a term of art. Many insurers consider a car as "totalled" when the cost of repair exceeds eighty percent of its precollision value. Thus, even a "totalled" car may have some residual or salvage value as a source of spare parts. In fact, the insured usually has a choice of collecting the entire precollision cash value of the car and allowing the insurer to have the "wreck," or keeping the "wreck" and having its salvage value deducted from its cash value. In this light, damaging the car after it is "totalled," or loosely described as "valueless," may further reduce its residual value and thus conceivably constitute a breach of the "protection" clause.

IV. CONSTRUCTION AND DEFINITIONS

A. "Arising out of the Operation, Maintenance, or Use of a Motor Vehicle"

In *King v. St. Paul Fire & Casualty Co.*,³⁹ a case that has the uncomfortable edge of our current reality about it, the insured was robbed and shot while occupying his motor vehicle. Did the insured sustain a compensable "bodily injury arising out of the operation, maintenance, or use" of his motor vehicle?⁴⁰ The court held that he did not.⁴¹ A greater nexus must exist between the shooting and the vehicle than the vehicle being the situs of the injury, or a showing that *but for* the insured's presence in or about the vehicle, the injury would not have occurred.⁴²

This orthodox conclusion, while well supported by Georgia precedent involving the discharge of firearms, is a bit facile because it ignores the common thread that runs through other decisions that have found the requisite vehicle-incident nexus to exist.⁴³ Coverage usually is found when the incident can be fairly said to arise from a "motoring risk." Thus, an injury sustained by a passenger sitting in a parked car when a limb fell from a tree and struck him on the back of the head was deemed to have arisen from the "use" of the car⁴⁴ and prompted the court to pronounce

38. The insurer designed the investigation to determine that the postcollision events precluded coverage and paid scant attention to the insured's claim that the car was "totalled" in the collision. The court held that this self-serving conduct justified a finding of bad faith. *Id.* at 679, 411 S.E.2d at 794.

39. 201 Ga. App. 851, 412 S.E.2d 614 (1991).

40. *Id.* at 851, 412 S.E.2d at 615 (quoting O.C.G.A. § 33-34-2(1) (1990)).

41. *Id.* at 852, 412 S.E.2d at 615.

42. *Id.*

43. See Maximilian Pock, *Insurance*, 43 MERCER L. REV. 285, 289-290 (1991).

44. *First Fin. Ins. Co. v. Rainey*, 195 Ga. App. 655, 394 S.E.2d 774 (1990), *aff'd in relevant part*, 261 Ga. 52, 401 S.E.2d 490 (1991).

that "almost any causal connection or relationship will do"⁴⁵ to bring the event within the sweep of coverage. On a parity of reasoning, one may conclude that the random shootouts in our urban streets and the dramatically increasing number of "carjackings" have made it just as likely for a hapless motorist to be hit by a bullet as by a falling tree limb.

B. Business

Providing child care and babysitting services in one's own home has become as American as the proverbial apple pie. Are such services covered by the liability floater in homeowners' policies, or are they excluded as business pursuits? Authorities in this country are sharply divided. The decision in *United Services Automobile Ass'n v. Lucas*⁴⁶ suggests that in Georgia this issue will not be decided by rubric but on a case-by-case basis.⁴⁷ Beyond acknowledging that in "some situations" child care in the home may be treated as a business pursuit, the court furnishes only the vaguest of guidelines in identifying these situations.⁴⁸ When the situation in question occurred, the insured was taking care of seven children, of whom four were her own grandchildren. Her gross income was \$100 a week. She had been a licensed day care operator for four years and had regularly taken care of children in her home. She also filed a Schedule C with the Internal Revenue Service, reporting her income and deducting her expenses.⁴⁹ Was she engaged in a "business," defined in the policy exclusion as including "trade, profession or occupation"?⁵⁰ The court held that she was not.⁵¹ Exclusions demand a narrow construction. The question was not whether the insured had subjectively treated her activities as a "business" for tax purposes and had obtained a license to pursue them, but whether her activities objectively rose to a level of a "business" within the intendment of the policy. Because her services were limited to seven children, of whom four were relatives;⁵² because her net income, as distinguished from her gross income, was negligible;⁵³ and because she did not solicit business but "offered her services as both a favor and a conve-

45. 195 Ga. App. at 656, 394 S.E.2d at 775 (quoting Southeastern Fidelity Ins. Co. v. Stevens, 142 Ga. App. 562, 563-564, 236 S.E.2d 550, 551 (1977)).

46. 200 Ga. App. 383, 408 S.E.2d 171 (1991).

47. *Id.* at 383, 408 S.E.2d at 171.

48. *Id.* at 384, 408 S.E.2d at 173.

49. *Id.* at 385, 408 S.E.2d at 173.

50. *Id.*

51. *Id.*

52. She was paid for taking care of her relatives, albeit at a reduced rate. *Id.* at 383, 408 S.E.2d at 172.

53. *Id.*

nience to parents who lived in the neighborhood,"⁵⁴ her activities amounted to no more than "babysitting for pinmoney" and could not be described as a "trade, profession or occupation."⁵⁵ One may assume that this beneficent test, with its quantitative/solicitation components, will only cause insurers to return to the drawing boards to craft a bullet-proof day care exclusion.⁵⁶

C. "Haulaway"

In *Stone v. Canal Insurance Co.*,⁵⁷ a pickup truck pulling an empty trailer was involved in a collision.⁵⁸ Was the truck an excluded "'haulaway,'" defined in the policy as an "'automobile[] used to tow, pull or transport automobiles, cargo or freight'?"⁵⁹ The court held that since the truck was not, when the collision occurred, used for any of the excluded purposes listed and since there was no showing that it was "exclusively or even commonly" used for such purposes, the case resisted disposition by summary judgment.⁶⁰ Whether the truck was within the reach of the exclusion did not depend on its design or its capacity of being put to the excluded use, but upon the quantum of such use. This was necessarily a question for the trier of fact.⁶¹

D. "Loss of Income or Earnings"

In *Davis v. Auto-Owners Insurance Co.*,⁶² the insured derived his income from selling salvageable scrap metal that he stored on his property. He claimed that an automobile injury and resulting temporary disability prevented him from selling off the remainder of his stock that was "sufficient to make several more [sales] trips to Atlanta,"⁶³ and thus caused

54. *Id.* at 385, 408 S.E.2d at 173.

55. The court distinguished *Nationwide Ins. Co. v. Collins*, 136 Ga. App. 671, 222 S.E.2d 828 (1975), because it contained a "modified" business pursuit exclusion unlike the exclusion in the present case. The exclusion in *Nationwide* applied to "activities in connection with a business *except such acts as are ordinarily incident to non-business pursuits.*" 200 Ga. App. at 384, 408 S.E.2d at 172 (quoting *Nationwide*, 136 Ga. App. at 674, 222 S.E.2d at 830).

56. It is difficult to imagine that a carefully drafted "day care" exclusion could be struck down as violative of public policy, particularly when one considers that such activity, no matter how socially useful, involves a considerable increase in the risk assumed by the insurer.

57. 200 Ga. App. 561, 408 S.E.2d 801 (1991).

58. *Id.* at 561, 408 S.E.2d at 801.

59. *Id.* at 563, 408 S.E.2d at 802.

60. *Id.*

61. *Id.*

62. 201 Ga. App. 331, 411 S.E.2d 84 (1991).

63. *Id.* at 331, 411 S.E.2d at 85.

him "the loss of income or earnings"⁶⁴ that he would have received during his disability. The court held his claim revealed only a delay in receiving income from the sale of his finite inventory of scrap and not a compensable present loss.⁶⁵ It would be otherwise if he had shown that his injury deprived him of a later opportunity to sell his stock and thus caused an irretrievable present loss.⁶⁶

E. "Standard Equipment"

Is the theft of an expensive \$2,900 custom stereo and alarm system, which the insured had installed in a \$14,200 automobile, compensable under a comprehensive coverage that includes the automobile and "its permanently attached equipment which is considered standard"?⁶⁷ In *Schoen v. Atlanta Casualty Co.*,⁶⁸ a case of first impression in this state, the court of appeals held that the theft was compensable.⁶⁹ Without being stretched to its maximum etymological range, the term "standard" yielded at least two acceptable meanings. First, "standard" could refer to "regular, typical or ordinary" equipment of a "quality or nature"⁷⁰ appropriate to an automobile in a particular price class and thus preclude custom accessories involving "extraordinary and disproportionate expenditure[s]."⁷¹ Second, "standard" could also refer "to the *type* of equipment usually, ordinarily or regularly found in automobiles," whatever its quality level or cost.⁷² Since the term was ambiguous, *contra proferentem* demanded construction in favor of the insured.⁷³

64. *Id.* (quoting O.C.G.A. § 33-34-4(a)(2)(B) (1982) (repealed 1991)). The No-Fault Act remains in effect as to all policies in existence on October 1, 1991, until they are modified at the request of the insured or until their renewal dates. 1991 Ga. Laws 1608, § 3.1.

65. 201 Ga. at 332, 411 S.E.2d at 85.

66. *Id.* (relying on cognate reasoning in *State Farm Mut. Ins. Co. v. Moss*, 152 Ga. App. 84, 262 S.E.2d 248 (1979)).

67. This language, which has surfaced in many policies of late, is more restrictive than that of the 1989 "easy reading" Personal Auto Policy that provides coverage for autos "including their equipment." KIT, *supra* note 32, at 7.

68. 200 Ga. App. 109, 407 S.E.2d 91 (1991).

69. *Id.* at 111, 407 S.E.2d at 92.

70. *Id.* at 110, 407 S.E.2d at 92.

71. *Id.*

72. *Id.*

73. Because the case concerned a doubtful question of law and was one of first impression, the insurer was not held liable for bad faith penalties and attorney fees. *Id.* at 111, 407 S.E.2d at 92.

V. COVERAGE LIMITATIONS

In *McCombs v. State Farm Mutual Automobile Insurance Co.*,⁷⁴ the insured, after being injured in an automobile collision involving one of his four cars, sought to aggregate or "stack" the medical expense coverages in four separate policies. He was a named insured in all policies that covered different vehicles and were written by the same insurer. The insured claimed that the standard "non-duplication" provisions contained in these policies did not prevent stacking because they were solely concerned with preventing insureds, under whatever pretext, from recovering twice for the same medical expense.⁷⁵ The court agreed that the "non-duplication" language posed no obstacle, and even conceded that "stacking" of medical expense coverages is generally permitted, unless the parties provide otherwise.⁷⁶ It so happened that another policy provision did just that. The provision listed the amount of medical expense coverage under "Limit of Liability-Coverage C. 1."⁷⁷ on the declaration page and stated in the medical expense endorsement, somewhat colloquially as befits a new wave "easy reading" policy, that "[t]his is the most we will pay for any one person under all medical payments coverage issued by us and applicable to the accident."⁷⁸

The insured contended that the "non-duplication" provision and the "limitation of liability" provision created an ambiguity that had to be resolved in his favor. The policy could hardly allow and forbid "stacking" at the same time.⁷⁹ The court skewered this spurious, if ingenious, contention by pointing out that the two provisions had entirely different objectives and did not relate to the same subject.⁸⁰ "The limitation of liability clause at issue, in the context of the entire policy, clearly and unambiguously prohibits the stacking of medical coverage payments . . ."⁸¹

VI. DEFENSE-LIABILITY INSURER'S OBLIGATION TO EXTEND

The liability insurer's duty to defend its insured is largely, although not exclusively, triggered by allegations in the complaint that disclose poten-

74. 200 Ga. App. 28, 406 S.E.2d 549 (1991).

75. *Id.* at 28, 406 S.E.2d at 550.

76. *Id.*

77. *Id.* at 29, 406 S.E.2d at 550 (quoting the policy).

78. *Id.* (quoting the policy). This language varies somewhat from the 1989 Personal Auto Policy that reads as follows: "This is the most we will pay regardless of the number of: . . . 'insureds' . . . [c]laims . . . [v]ehicles or premiums shown . . . or . . . [v]ehicles involved . . ." KIT, *supra* note 32, at 5.

79. 200 Ga. App. at 29, 406 S.E.2d at 551.

80. *Id.*

81. *Id.*

tial coverage.⁸² The decision in *Batson-Cook Co. v. Aetna Insurance Co.*⁸³ concerned two suits against a construction management company that had been hired by a developer to provide management services in connection with a building project. The suits were brought by different contractors employed on the same project. The first suit alleged that the company had "negligently performed its duties as supervisor of the project, resulting in damages to the plaintiff for . . . loss of use of equipment."⁸⁴ The second alleged that the company had "breached its duties as construction manager . . . by 'directing other contractors and subcontractors to use . . . equipment . . . rented by or belonging to plaintiff,'"⁸⁵ which deprived plaintiff of the equipment's use and resulted in " 'damage to . . . equipment during periods of unauthorized use.' "⁸⁶ Both comprehensive general liability ("CGL") policies potentially present upon the risk provided for " 'property damage . . . caused by an occurrence.' "⁸⁷ " 'Property damage' " was defined, *inter alia*, as " 'physical injury to or destruction of tangible property . . . or . . . loss of use of tangible property which has been physically injured or destroyed provided such loss of use is caused by an occurrence.' "⁸⁸ " 'Occurrence' " was defined as " 'an accident, including continuous or repeated exposure to conditions, which results in . . . property damage neither expected nor intended from the standpoint of the insured.' "⁸⁹ The court held that the insurers were under no obligation to defend the first suit because there was no allegation that the loss of use of the equipment was caused by any physical damage to the equipment itself.⁹⁰ Nor were they under any obligation to defend the second suit even though it alleged potentially covered claims.⁹¹ The reason was that both policies contained the standard exclusion for " 'liability assumed by the insured under any contract or agreement.' "⁹² Since the loss, if any, was alleged to have resulted from an excluded

82. *Great Am. Ins. Co. v. McKemie*, 244 Ga. 84, 259 S.E.2d 39 (1979), *rev'g McKemie v. Great Am. Ins. Co.*, 149 Ga. App. 19, 253 S.E.2d 399 (1979). It should be noted that some decisions hinge on the specific language of the policy that may narrow or enlarge the duty to defend. See ROBERT E. KEETON, *BASIC TEXT ON INSURANCE LAW* § 7.6(a), at 462-77 (1971).

83. 200 Ga. App. 571, 409 S.E.2d 41 (1991).

84. *Id.* at 572-73, 409 S.E.2d at 43.

85. *Id.* at 573, 409 S.E.2d at 43 (quoting the complaint).

86. *Id.* at 574, 409 S.E.2d at 43 (quoting the complaint).

87. *Id.* at 573, 409 S.E.2d at 43 (quoting the policy).

88. *Id.* (quoting the policy).

89. *Id.* (quoting the policy).

90. *Id.* at 574, 409 S.E.2d at 44.

91. *Id.*

92. *Id.*, 409 S.E.2d at 43 (quoting the policy).

breach of contract, it was not covered and hence could not trigger any defense duties.⁹³

Moreover, one of the policies contained the standard exclusion for "damage arising out of the rendering of or the failure to render any professional services . . . , including . . . supervisory, inspection or engineering services."⁹⁴ This exclusion furnished an independent basis for a preclusion of coverage.

Although *Batson-Cook* is above criticism, the standard CGL policies that it construed are not. One cannot but wonder if the scope of their coverages, as diminished by surgical exclusions, meets the basic expectations of the insured in the peculiar business setting from which they arise. The "contract or agreement" exclusion denies coverage for property damage flowing indirectly from the insured's faulty decisions in the performance of its contract. The two-tiered and circuitous definition of "occurrence," which requires that the cause of property damage be accidental and that its result be unexpected, tends to cut the coverage even further. Taken literally, the "contract or agreement" exclusion seems to cause the policy to fail of its essential purpose, if the purpose of a CGL policy can be described as covering the insured's liability for negligent damage to property. If one disregards instances of strict liability, culpability is the basis of torts law. Since one is ordinarily not liable for accidents, a policy covering liability for accidental damage is, at least facially an oxymoron. Redefining "occurrence" as damage to property caused by but not expected or intended by the insured would be fairer.

VII. DIRECT ACTION AGAINST LIABILITY INSURERS

Two United States Territories and three states have so-called direct action statutes that permit suit against liability insurers before their formal liability is established by judgment against, or settlement with, the insured.⁹⁵ Georgia has only a direct action statute that permits the joinder of motor carriers and their insurers in the same action.⁹⁶ The statute also permits an independent action "against the insurer . . . without joinder of the motor carrier . . . [a]s an independent *ex contractu* action on the policy itself . . . nonancillary to the *ex delicto* action against the motor carrier."⁹⁷ Outside of this integument, direct actions are only permitted when the policy so provides.

93. *Id.*, 409 S.E.2d at 44.

94. *Id.*, 409 S.E.2d at 43-44 (quoting the policy).

95. ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW § 84(b) (1987).

96. O.C.G.A. §§ 46-7-12(e), -58(e) (1982).

97. *Thomas v. Bobby Stevens Hauling Contractors*, 165 Ga. App. 710, 714, 302 S.E.2d 585, 588-89 (1983).

In *Bacon v. Liberty Mutual Insurance Co.*,⁹⁸ plaintiff sustained injuries on the premises of a Bi-Lo store. She sued the insurer directly for payment of her medical bills.⁹⁹ The court reiterated the general rule that such action could not be brought “unless there is an unsatisfied judgment against the insured or it is specifically permitted either by statute or a provision in the policy.”¹⁰⁰ The court held, however, that the procedural posture of the case precluded disposition by judgment on the pleadings in favor of the insurer.¹⁰¹ In her complaint, plaintiff made the conclusionary allegation that her claim was “[b]ased on that policy,” but failed to put the policy itself into the record.¹⁰² Since courts, when passing upon motions for judgment on the pleadings, are enjoined to treat “all well-pleaded material allegations of the opposing party’s pleading . . . as true,” there existed “the remote possibility” that the complaint stated a cause of action.¹⁰³ The result would have been otherwise had the complaint specifically negated the existence of a third party beneficiary clause permitting a direct action.

VIII. ERRORS & OMISSIONS POLICIES

The increasingly popular “claims made” or “discovery” liability policies cover events that occur after the (usually retroactive) inception date of the policy if a claim is made against the insured and reported to the insurer during the coverage term. “Occurrence” policies cover events that happen during the coverage term, even if they are not discovered, or result in a claim, until long after the coverage term.¹⁰⁴ Because occurrence policies have “long tails” that may produce actuarial nightmares at a time when our malpractice insurance crisis cries out for reduction of insurance costs, occurrence policies have been replaced increasingly by “claims made” policies. This trend has even carried over to CGL policies issued to businesses. The case of *Serrmi Products, Inc. v. Insurance Co. of Pennsylvania*¹⁰⁵ concerned a policy covering “such claims as were made against [the insured] between March 1, 1987 and March 1, 1988.”¹⁰⁶ The policy provided for a sixty-day “automatic limited Extended Reporting Period” that lengthened the coverage term for claims made and reported within

98. 198 Ga. App. 436, 401 S.E.2d 625 (1991).

99. *Id.* at 436, 401 S.E.2d at 625.

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*, 401 S.E.2d at 625-26.

104. See KEETON & WIDISS, *supra* note 33, § 5.10(d)(3).

105. 201 Ga. App. 414, 411 S.E.2d 305 (1991).

106. *Id.* at 414, 411 S.E.2d at 306.

sixty days.¹⁰⁷ The policy also contained a two-year "automatic limited Extended Reporting Period which was applicable only to claims as a result of an "occurrence" covered by this policy which [had] been reported . . . not later than 60 days after the end of this policy.'"¹⁰⁸ A claim was made against the insured and reported to the insurer after expiration of the sixty-day period but before expiration of the two-year period.¹⁰⁹ Was it covered? The court held emphatically that it was not.¹¹⁰ Had the claim been made and reported before expiration of the sixty-day period it would have been covered because the period effectively extended the original one-year coverage term. The two-year "Extended Reporting Period" applied only if the claim was made and reported within two years after the original coverage term *and* if the claim had its origin in a covered event that occurred during the original policy term and was reported to the insurer no later than sixty days after expiration of that term. The addition of this hybrid "occurrence" feature could have no bearing upon the basic character of the insurer's undertaking, which was to provide a "claims made" policy. The essence of a "claims made" policy is that claims be made and reported within the coverage period. If the court were to excuse late reporting just because the insured had been unaware of any "occurrence" during the coverage term, it would in effect extend the coverage term and rewrite the parties' contract.¹¹¹

IX. EXCEPTIONS AND EXCLUSIONS

In *Jefferson Pilot Life Insurance Co. v. Clark*,¹¹² a case of first impression, the beneficiary of a group accidental death policy "was killed in a one-car collision in which he was the driver and sole occupant."¹¹³ A blood alcohol test taken after his death revealed that his blood alcohol content was .15 percent,¹¹⁴ which "is almost *twice* the . . . concentration at which one is *presumed* to be under the influence of alcohol."¹¹⁵ Relying on an exclusion in the master policy, the insurer denied coverage. The exclusion states in pertinent part that "[t]his policy does not cover any loss, *caused by or resulting from . . . any injury sustained while operating a motor vehicle if the covered person was under the influence of alco-*

107. *Id.*

108. *Id.* at 414-15, 411 S.E.2d at 306 (quoting the policy).

109. *Id.* at 415, 411 S.E.2d at 307.

110. *Id.* at 416, 411 S.E.2d at 307.

111. *Id.* at 415, 411 S.E.2d at 307 (relying on *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512 (Fla. 1983)).

112. 202 Ga. App. 385, 414 S.E.2d 521 (1991).

113. *Id.* at 385, 414 S.E.2d at 522.

114. *Id.*

115. *Id.* at 389, 414 S.E.2d at 525.

hol as evidenced by a blood alcohol level of at least 0.15%.'"¹¹⁶ Did this language require not only that the loss be *caused* by injury but also that the injury itself be *caused* by the operation of the vehicle or by the manner in which it was operated? Over a trenchant dissent by Judge Pope,¹¹⁷ the court held that it did not.¹¹⁸ The language was unambiguous. It required "only an 'injury' which is '*sustained while*' [the insured] '*operated*' the car while under the influence of alcohol."¹¹⁹ In its common signification, the word "sustain" does not connote causation but just the opposite. In the context of the exclusion, "sustain" means "to experience, receive, undergo, bear, or suffer."¹²⁰ Thus, the word "sustain," even when stretched to its maximum etymological limits, cannot be used to force a causation requirement into the exclusion.¹²¹ The court explained that had the insured sought more extensive coverage than the group policy provided, he would have been free to purchase an individual policy, which would have provided additional protection through a causation requirement mandated by statute.¹²²

Did the exclusion violate Georgia public policy? Quite the contrary. The exclusion was "consistent with the state's public policy of improving safety on the [public] highways by eliminating from its . . . highways drivers who are under the influence of alcohol."¹²³ Moreover, the insurance contract at issue was a group accidental death policy beyond the parameters of compulsory motor vehicle insurance statutes.¹²⁴ It was thus appropriate for the insurer "to exclude from coverage a class which can be expected reasonably to sustain proportionately higher numbers of accidental injuries or death because of their own misconduct, thus reducing insurance premiums in accordance with public policy."¹²⁵

X. INSURANCE AGENTS AND BROKERS

When an insurance agent fraudulently secures the issuance of a policy by erroneously recording on an application information that was supplied correctly by the applicant, the insurer is usually bound. The insurer is estopped from claiming that it issued the policy in reliance upon the mis-

116. *Id.* at 386, 414 S.E.2d at 523 (quoting the policy) (emphasis added).

117. *Id.* at 393-96, 414 S.E.2d at 528-30.

118. *Id.* at 388, 414 S.E.2d at 525.

119. *Id.* at 387, 414 S.E.2d at 524 (quoting the policy).

120. *Id.* (relying on the congruent definitions found in four different dictionaries).

121. *Id.*

122. *Id.* at 388, 414 S.E.2d at 524 (citing O.C.G.A. § 33-29-4(b)(9) (1982)).

123. *Id.* at 389, 414 S.E.2d at 525 (citations omitted).

124. *Id.* at 385, 414 S.E.2d at 522.

125. *Id.* at 390, 414 S.E.2d at 526.

representation because of its imputed knowledge of the truth.¹²⁶ What happens when the insurer discovers the misrepresentation and refuses to issue the policy? This question is partially answered in *James, Hereford & McClelland, Inc. v. Powell*,¹²⁷ a case of first impression, which has already made its second appearance before the court of appeals. Reduced to its simplest elements, the case reveals the following scenario: an unsuccessful applicant for disability insurance brought an action against an independent agent alleging that he had been damaged by the agent's fraud in completing and processing the application. The applicant claimed the agent had falsely and fraudulently entered upon the application information that the applicant had correctly supplied. The evidence disclosed that the insurer declined to issue a policy for material misrepresentation after receiving information that the applicant was permanently disabled. It was also shown that the truthful disclosure of the applicant's disability in the application would not only have resulted in the rejection of his application, but also would have prevented him from securing insurance from any other source.¹²⁸

Did this scenario reveal that the applicant had suffered any loss? The court most emphatically held that it did not.¹²⁹ The applicant's bizarre argument amounted basically to this: Had the agent's alleged "fraud" succeeded, he would now have a claim against the insurer. Since it failed, he must now necessarily have a claim against the agent whose conduct deprived him of the insurance he would otherwise have obtained. This argument created an injury that was "entirely illusory."¹³⁰ The argument ignored that the agent's alleged misrepresentations were not directed against the applicant but against the insurer. Allowing the applicant to rely upon these representations as a basis for damages "would be to suborn fraud and encourage collusion."¹³¹ The argument also ignored the conclusion that the application would have been rejected even if it had contained the correct information. Thus, ultimately the applicant's uninsurability, and not the discovery of the misrepresentation, caused the application to be rejected.¹³²

126. For a general discussion of Georgia's "estoppel-by-imputed-knowledge" rule, see Maximilian Pock, *Insurance*, 24 MERCER L. REV. 159, 159-61 (1973).

127. 198 Ga. App. 604, 402 S.E.2d 348 (1991).

128. *Id.* at 604-05, 402 S.E.2d at 349-50.

129. *Id.* at 606, 402 S.E.2d at 350.

130. *Id.*

131. *Id.*

132. One may conjecture that the applicant may have had a claim against the agent had he been able to show that other insurers might have insured him but for the fact that the Medical Information Bureau indicated that he was now a "moral" risk because he was "linked" to the agent's misrepresentation.

The court also concluded that the applicant could not rely upon the alleged misrepresentation because the agent was at all pertinent times the agent of the insurer and thus did not occupy the status of a fiduciary in relation to the applicant.¹³³ Moreover, the specific language of the application precluded such reliance because it instructed the applicant to certify the truth of his declarations to the best of his knowledge and belief.¹³⁴

XI. JUDGMENT IN EXCESS OF POLICY LIMITS

What is the posture of affairs when a liability insurer fails to take the opportunity to settle a claim within the policy limits and a judgment is entered against its insured that is above the policy limit? Such cases tend to represent a veritable quagmire for factfinders and judges alike. In Georgia the insurer is liable for the full amount of the judgment unless it has acted without negligence and in good faith and given "equal thought" or "equal consideration" to the insured's and its own interest in refusing the settlement. Since it is nearly always in the best interest of the insured to settle within or at the policy limit, and in the best interest of the insurer to pay nothing or as little as possible, this "equal thought" test completes the rout of many jurors who realize that the two interests simply defy reconciliation. Even after the jury has returned a verdict under appropriate instructions (which raise contentious issues of their own), the inevitable motions for judgment notwithstanding the verdict cause trial and appellate courts much agony.¹³⁵

The litigation context of *Allstate Insurance Co. v. Evans*,¹³⁶ a case of first impression, is a bit out of the ordinary because it did not contain the usual garden-variety claim that the insurer used bad faith in refusing a settlement but a claim that it used bad faith in effecting a settlement. Complainants filed an action for personal injuries against the insured within twelve months after a multi-vehicle collision, which allegedly was caused by the negligence of the insured. They obtained a judgment of \$35,000 each. While their actions were pending the "insurer settled certain suits which had been filed against the insured by other claimants

133. 198 Ga. App. at 606, 402 S.E.2d at 350.

134. There was also evidence that the applicant himself had consciously suppressed information relevant to his medical impairment that constituted "an independent controlling reason" why he could not recover for fraud. *Id.* at 608, 402 S.E.2d at 352.

135. For a paradigmatic case on all these points that, at the time of this writing has yet to await its imprimatur or reversal by the supreme court, see *Southern Gen. Ins. Co. v. Holt*, 200 Ga. App. 759, 409 S.E.2d 852 (1991), *aff'd in part, rev'd in part*, 262 Ga. 267, 416 S.E.2d 274 (1992).

136. 200 Ga. App. 713, 409 S.E.2d 273 (1991).

more than [twelve] months after the accident"¹³⁷ and thus nearly exhausted the coverage limit. As a result, only \$50,000 remained to pay the \$70,000 represented by the claimants' judgments.¹³⁸ Was the insurer liable for the full amount of their judgments? The court held that it was not.¹³⁹ The only Georgia statute remotely touching upon this case provided that "all judgments . . . growing out of a common disaster . . . shall be equal in rank or priority regardless of the date of the rendition of the verdict or the entering of the judgment."¹⁴⁰ This statute obviously had no application because judgment liens were not at issue. Consequently, the court looked to other jurisdictions for guidance. The court discovered that a liability insurer generally is permitted "in good faith and without notification to others, [to] settle part of multiple claims against its insured *even though such settlements deplete or exhaust the policy limits* so that the remaining claimants have no recourse against [the] insurer."¹⁴¹ The court adopted this rule for Georgia and applied it to the present case because it was persuaded by its rationale, which it adumbrated as follows:

Were the rule otherwise, an insurer would . . . be required to await the reduction of all claims to judgment before paying any of them, no matter how favorable . . . the terms of a proposed settlement might be. Such a policy would obviously promote litigation and would also *increase the likelihood . . . that the insured would be left with a total adjudicated liability in excess of his policy limits.*¹⁴²

Since there was no allegation, nor any evidence indicating that the insurer's disbursement of the liability fund was in bad faith, the insurer could not be compelled to make up the claimants' shortfall.¹⁴³

This conclusion is obviously based on portions of the record that have not surfaced in the appellate opinion. Surely the policy must have contained the ubiquitous "private" statute of limitations requiring one to bring all actions within twelve months after the accident or occurrence. The stipulated facts reveal that the settlement involved suits "which had been filed against the insured by other claimants *more than 12 months after the accident.*"¹⁴⁴ It would seem that an insurer, while free to waive such limitation as far as its own interests are concerned, would not be

137. *Id.* at 713, 409 S.E.2d at 273.

138. *Id.* at 713-14, 409 S.E.2d at 273-74.

139. *Id.* at 715, 409 S.E.2d at 274.

140. *Id.* at 714, 409 S.E.2d at 274 (citing O.C.G.A. § 9-12-90(a) (1982)).

141. *Id.* (quoting 7C JOHN A. APPLEMAN, INSURANCE LAW & PRACTICE § 4711, at 409 (rev. ed.) (emphasis added)).

142. *Id.* at 715, 409 S.E.2d at 274 (emphasis added).

143. *Id.*

144. *Id.* at 713, 409 S.E.2d at 273 (emphasis added).

free to do so when such generosity adversely affects claimants who had perfected their rights by timely compliance with the policy's limitations on actions. One may conjecture that such conduct either could be classified as bad faith as a matter of law or at least as evidence of bad faith so as to raise an issue for the triers of fact.¹⁴⁵

XII. LIMITATION IN POLICY—TIME FOR SUIT

The case of *Giles v. Nationwide Mutual Fire Insurance Co.*¹⁴⁶ contained a new "easy reading" homeowners' policy¹⁴⁷ that provided as follows: "Suit Against Us. No action can be brought unless . . . the action is started within one year after the date of loss or damage."¹⁴⁸ Was the word "action" ambiguous in the sense that it "could be interpreted to mean any action undertaken by an insured to assert a claim, not just the initiation of a lawsuit,"¹⁴⁹ thus inviting application of *contra proferentem*? The court held that it was not.¹⁵⁰ When viewed against the introductory heading "[s]uit against us," it could only be interpreted in its plain and ordinary signification as a formal judicial proceeding to assert a claim by filing an action in a court of law.¹⁵¹ This rules out nonjudicial actions, such as filing proofs of loss or making formal demands for payments of claims. By now it is quite futile to challenge such "private" one-year statutes of limitations on the grounds that they cut short the otherwise applicable limitation in violation of the state's declared public policy on the "staleness" of claims.¹⁵² One may, however, challenge their specific application in an individual case by showing that the insurer had, by word or conduct, lulled the insured into a belief that the limitation would not be asserted or that the claim would be settled without litigation. The decision in *Giles* demonstrates that this is not an easy task.¹⁵³ The parties had engaged in protracted negotiation for eleven months. These negotiations were punctuated by acrimonious disagreements over sites where sworn statements were to be taken, by a rejected settlement offer, and by

145. The case had been submitted to the bench on stipulated facts. *Id.*, 409 S.E.2d at 274.

146. 199 Ga. App. 483, 405 S.E.2d 112 (1991).

147. 1984 Homeowners Policy HO 3 Special Form, KIT, *supra* note 32, at 17-35.

148. 199 Ga. App. at 484, 405 S.E.2d at 113. The Standard Fire Insurance Policy is more precise on this point. It states that "[n]o suit or action . . . shall be sustainable in any court of law or equity." KEETON, *supra* note 82, at 596 (Appendix A).

149. 199 Ga. App. at 484, 405 S.E.2d at 113.

150. *Id.*

151. *Id.*, 405 S.E.2d at 114.

152. The Uniform Commercial Code allows the parties to "whittle" down the four-year statutory limitation to one year. O.C.G.A. § 11-2-725(1) (1982).

153. 199 Ga. App. 483, 405 S.E.2d 112 (1991).

a letter threatening court action if payment was not received within sixty days. Negotiations were finally broken off one month before expiration of the limitation by the insurer's unequivocal denial of the claim.¹⁵⁴ The court held that this left the insured sufficient time to make good on his threat to file suit within the one-year policy limitation and, thus, did not raise an estoppel against the insurer.¹⁵⁵

XIII. MISREPRESENTATIONS

In Georgia the law of misrepresentation works with the precision of a guillotine, as is demonstrated by *Davis v. John Hancock Mutual Life Insurance Co.*¹⁵⁶ The applicant for a "Military Spouse Life Insurance" certified in her application that she was in good health and not under medical care. Actually, her physician had just discovered in the course of a routine consultation for facial acne that she was anemic. Although he suspected only an iron deficiency, the physician advised her to return for further tests. Subsequently, it was discovered that she suffered from incurable lymphoma, a malignancy that objectively had existed on the date of the application and that caused her death eighteen months later.¹⁵⁷ Georgia law provides in pertinent part that "[m]isrepresentations . . . and incorrect statements shall not prevent a recovery under the policy . . . unless . . . [m]aterial either to the acceptance of the risk or to the hazard assumed by the insurer."¹⁵⁸ Since uncontroverted evidence established that the condition was material, its misstatement allowed the insurer to deny liability. As previously construed by the supreme court, the statute drew "no distinction between statements regarding asymptomatic, latent or unknown diseases and diagnosed, manifested diseases,"¹⁵⁹ and thus did not provide for a "good faith" exception.¹⁶⁰

The insurer was so confident that it relied upon the erroneous assertion of good health alone, without pointing out that the applicant may also have misstated that she was under medical care. The insurer also failed to draw the court's attention to the fact that the policy itself made good health a condition precedent to eligibility for insurance. This treatment of innocent misrepresentations is well nigh universal in this country.¹⁶¹ Isolated cases holding that assertions of good health represent but opin-

154. *Id.* at 484, 405 S.E.2d at 113.

155. *Id.* at 485, 405 S.E.2d at 114.

156. 202 Ga. App. 3, 413 S.E.2d 224 (1991).

157. *Id.* at 3-4, 413 S.E.2d at 225.

158. *Id.* at 5, 413 S.E.2d at 226 (quoting O.C.G.A. § 33-24-7(b) (1982)).

159. *Id.* at 6, 413 S.E.2d at 226.

160. *Id.*

161. See generally KEETON & WIDISS, *supra* note 33, § 5.7.

ions, which are only actionable if they are deliberately falsified, have been largely ignored or weakened.¹⁶²

XIV. OMNIBUS CLAUSE

The decision in *Rogers v. Travelers Indemnity Co.*¹⁶³ represents a contemporary cultural pastiche. Before the accident in question, Patrick, Sonny, and Jeffrey had been smoking marijuana and drinking beer in the home of Jeffrey's parents, who were out of town at the time. Although Jeffrey's father had prohibited the use of the family's pickup truck, Sonny somehow managed to get the keys to the truck and allowed Patrick to take the wheel. Patrick promptly had an accident. He assumed "that me and Sonny both had permission to drive [the truck] because [Sonny] came out with the keys, so I figured he had already asked [Jeffrey]."¹⁶⁴ Was Patrick covered under his father's automobile policy that extended to his use of a non-owned vehicle " 'if the use is [or is reasonably believed to be] with the owner's permission' " ?¹⁶⁵ The court held that he was not.¹⁶⁶ Being fifteen years old at the time and in possession of "a restricted learner's license which permitted him to operate a motor vehicle only if accompanied by a licensed driver 18 years of age or older,"¹⁶⁷ he could not have formed a reasonable belief that the owner had given his permission to use the vehicle when Sonny, a sixteen year old, allowed him to get behind the wheel.¹⁶⁸

The court also made short shrift of the argument that noncoverage of nonowned automobiles in these circumstances was violative of public policy.¹⁶⁹ It was one thing for public policy to enlarge "an insurer's risk where acts of the undisputed insured driver are concerned" and quite another to affix liability upon the insurers for unauthorized acts of persons who are not insured at all.¹⁷⁰ On a parity of reasoning, the court of ap-

162. See, e.g., *Metropolitan Life Ins. Co. v. Burno*, 33 N.E.2d 519 (Mass. 1941), one of the benchmark cases on the "opinion" rule, which was subsequently etiolated by *Pahigian v. Manufacturer's Life Ins. Co.*, 206 N.E.2d 660 (Mass. 1965). Gone are the days when Professor Vance, albeit on the strength of ancient authority, could assert confidently that the "opinion" rule applied to "representations as to the health of the insured, so far as latent diseases are concerned." WILLIAM VANCE, HANDBOOK ON THE LAW OF INSURANCE 403-04 (1951).

163. 202 Ga. App. 77, 413 S.E.2d 254 (1991).

164. *Id.* at 77-78, 413 S.E.2d at 255.

165. *Id.* at 77, 413 S.E.2d at 255 (quoting the policy).

166. *Id.* at 78, 413 S.E.2d at 255.

167. *Id.*

168. *Id.*

169. *Id.* at 79, 413 S.E.2d at 256.

170. *Id.*

peals in *Safeway Insurance Co. v. Jones*¹⁷¹ held that a sixteen year old unlicensed driver could not form a reasonable belief that a car's owner and named insured had given him permission to use the vehicle just because his girlfriend, the owner's daughter, had allowed him to drive it.¹⁷²

XV. PRIMARY AND EXCESS INSURERS

When an automobile rental agency leases a car, what is the relationship or "interface," as modernists would put it, between the owner/lessor's insurance and the driver/lessee's insurance? The decision in *Jones v. Wortham*,¹⁷³ a case of first impression, gives a partial answer to this question. The lessee carried a liability policy on her own car, which, as is customary, provided only insurance in "excess of any other collectible insurance" whenever she operated a nonowned vehicle.¹⁷⁴ The lessor furnished insurance on its own vehicle in accordance with a self-insurer certificate as mandated by statute.¹⁷⁵ The car rental agreement at issue provided conspicuously that "RENTER FURTHER AGREES THAT AAA Rent-A-Car, Inc. FURNISHES NO INSURANCE WHATSOEVER TO THE RENTER and renter expressly agrees and warrants that he has insurance that covers the rental vehicle . . . and his insurance is primary coverage."¹⁷⁶ This agreement thus reflected in part the statutory mandate "that lessees from U-drive-it agencies furnish their own insurance."¹⁷⁷ Did this mean that rental agencies could completely exempt themselves from providing any liability insurance for their clients? No, said the court, for two reasons.¹⁷⁸ First, when read together with the self-insurance certificate, the rental agreement is ambiguous because the phrase "NO INSURANCE WHATSOEVER"¹⁷⁹ fails to "specify whether the insurance mentioned is liability insurance, which inures to the benefit of third parties, or [first party] insurance, which only covers the driver and/or the vehicle involved."¹⁸⁰ This ambiguity had to be resolved in favor of the insured. Hence, the rental agreement could not be construed as an attempt to exempt the lessor from supplying liability insurance for the lessee.¹⁸¹ Second, the statute requiring lessees to "furnish their own insur-

171. 202 Ga. App. 482, 415 S.E.2d 19 (1992).

172. *Id.* at 483, 415 S.E.2d at 20.

173. 201 Ga. App. 668, 411 S.E.2d 716 (1991).

174. *Id.* at 670, 411 S.E.2d at 718.

175. *Id.* at 668, 411 S.E.2d at 717.

176. *Id.* at 669, 411 S.E.2d at 717 (quoting from rental agreement).

177. *Id.* (paraphrasing O.C.G.A. § 40-9-102 (1991)).

178. *Id.*

179. *Id.* (quoting from the rental agreement).

180. *Id.*

181. *Id.*

ance"¹⁸² does not facially or otherwise purport to exempt lessors from their general statutory duty to provide liability insurance for their own vehicles.¹⁸³

Thus, there remained but one issue: Was the liability coverage under the self-insurer certificate "excess" or "primary"? The court noted that Georgia has made several exceptions to the general statutory scheme treating the owner's insurance as primary.¹⁸⁴ Although the requirement that "lessees from U-drive-it agencies furnish their own insurance"¹⁸⁵ does not directly speak to this specific issue, it should be read as creating such exception by clear implication. Given the special legislative treatment of the lessor-lessee relationship, it follows that the lessor is only required to furnish excess insurance despite the presence of a conflicting "excess insurance" clause in the lessee's policy. From the vantage point of the lessee's liability carrier, there was no "collectible insurance" in regard to which it provided only excess coverage.¹⁸⁶

In *International Indemnity Co. v. Keith*,¹⁸⁷ an employee struck and killed a bicyclist while driving his employer's truck. The employee's wife carried a liability policy on her Monte Carlo, which also covered her husband as an additional insured under its omnibus clause.¹⁸⁸ The policy contained the standard excess coverage for nonowned vehicles but excluded liability coverage for "any vehicle which is owned by or furnished or available for the regular use of any family member."¹⁸⁹ Since uncontroverted evidence established that the truck involved in the accident was not only furnished for the regular use by the employee but also regularly used by him, the court held that his wife's policy furnished no coverage, excess or otherwise.¹⁹⁰

In the case under consideration, the wife's liability carrier sought a declaratory judgment to determine coverage. Recourse to this procedure is, of course, barred after the insurer has denied liability because such denial eliminates the very issue that prompts the insurer to seek the court's guidance. The court held, however, that such denial must be firm and

182. *Id.*

183. *Id.* (citing O.C.G.A. § 33-34-4(a) (1982)). Note that this section was amended by 1991 Ga. Laws 1608, § 1.12 and redesignated O.C.G.A. § 33-34-4 (Supp. 1992). The amendment did not effect any substantive change for purposes of this discussion.

184. 201 Ga. App. at 670, 411 S.E.2d at 718. The court listed as an example O.C.G.A. § 33-34-3(d) (Supp. 1992), which allows the driver's insurance to be primary whenever the vehicle driven is owned by an automobile dealer.

185. 201 Ga. App. at 669, 411 S.E.2d at 717.

186. *Id.* at 670, 411 S.E.2d at 717-18.

187. 199 Ga. App. 171, 404 S.E.2d 335 (1991).

188. *Id.* at 172, 404 S.E.2d at 336.

189. *Id.* (quoting the policy).

190. *Id.* at 173, 404 S.E.2d at 336-37.

undisputed to justify dismissal of the declaratory judgment action.¹⁹¹ If the record does not disclose such denial the action must be allowed to proceed.¹⁹²

Finally, in *Ryan v. State Farm Mutual Automobile Insurance Co.*,¹⁹³ the supreme court answered a question certified by the United States Court of Appeals regarding cost allocations between statutory no-fault ("PIP") coverages, and optional nonstatutory medical payments coverages.¹⁹⁴ The policy at issue provided in its PIP coverage that up to \$2,500 of the \$5,000 aggregate limit was payable for medical expenses and up to \$1,500 was payable for funeral expenses. In case of the insured's death, an amount up to the \$5,000 aggregate limit was available to the spouse or dependent children as a survivors' loss benefit.¹⁹⁵ In its "medical payments" endorsement, the policy also provided for a \$5,000 aggregate limit "for medical expenses, including funeral services" of up to \$2,500 per person. The insured died from injuries sustained in an automobile collision. His death resulted in about \$3,600 for burial expenses and \$75 for medical expenses in the form of ambulance services.¹⁹⁶ Did the policy allow the beneficiary to "maximize" coverage by allocating the entire \$5,000 PIP limit to the payment of the survivors' loss benefit, which would cause the "medical payments" coverage to pick up the slack for medical expenses and funeral services? The court noted that the Georgia Motor Vehicle Accident Reparations Act "does not specify the order in which the no-fault benefits it requires shall be paid."¹⁹⁷ Thus, the allocation of benefits was left to party autonomy.¹⁹⁸ Unfortunately for the beneficiary, this autonomy was exercised when the insurer provided in its "medical payments" endorsement that "[t]his coverage is *excess* over any medical or funeral expense paid or payable *under the no-fault coverage* of this or any other policy."¹⁹⁹ Clearly this demanded that PIP benefits be applied first to medical and funeral expenses up to their stated limits before the beneficiary had an opportunity to "dip" into the excess medical and funeral expense coverage afforded under the "medical payments" endorsement.²⁰⁰

191. *Id.* at 172, 404 S.E.2d at 336.

192. *Id.* at 173, 404 S.E.2d at 337.

193. 261 Ga. 869, 413 S.E.2d 705 (1992).

194. *Id.* at 869, 413 S.E.2d at 705.

195. *Id.* at 870, 413 S.E.2d at 706.

196. *Id.* at 870-71, 413 S.E.2d at 706.

197. *Id.* at 873, 413 S.E.2d at 708.

198. *Id.*

199. *Id.* at 870, 413 S.E.2d at 706 (emphasis added).

200. Note that within the PIP coverage itself the insured, and not the insurer, may determine the order of payment of the various categories of benefits. *State Farm Mut. Auto. Ins. Co. v. Ainsworth*, 198 Ga. App. 740, 402 S.E.2d 759 (1991).

XVI. PROCEDURE

In *State Farm Mutual Automobile Insurance Co. v. Lorenz*,²⁰¹ the insured sued her uninsured motorist carrier ("UMC") to tap two "stackable" uninsured motorist endorsements available to her under the automobile policies issued to her by the UMC. She alleged that her damages "greatly exceeded" the limits of the alleged tortfeasor's liability policy. Unfortunately, however, she had entered into a settlement agreement with the tortfeasor's liability insurer and had executed a complete release in return for an amount that was only slightly below the liability limit.²⁰² Could she still collect from her UMC? She definitely could not. The court reiterated that it is an irrefragable requirement under Georgia law that she first file an action and secure a judgment against the known or unknown tortfeasor.²⁰³ This condition precedent to recovery against the UMC cannot be satisfied by any alternative ways of fixing the alleged tortfeasor's liability. Since the record showed conclusively that the statute of limitations now barred this action, the trial court was in error when it denied the UMC's motion for summary judgment.²⁰⁴

It may be observed parenthetically that settlement with an alleged tortfeasor for an amount at or near the limit of the liability policy is obviously more cost effective than obtaining a judgment, particularly when there are, as a practical matter, no assets beyond the liability policy. It is equally obvious, however, that such settlement may be prejudicial to the UMC because it may compromise the insurer's subrogation rights if the tortfeasor turns out to be less impecunious than assumed.²⁰⁵ Hence, legislative tampering with the exclusive "action/judgment" requirement does not seem called for.

The decision in *McCary v. Preferred Risk Mutual Insurance Co.*²⁰⁶ concerned a cognate issue. The insured filed an action against the uninsured motorist only three days before the statute of limitations expired. Timely personal service upon the uninsured motorist proved abortive because he did not reside at the address furnished by the insured. It was not until seventeen months after filing the action that the insured made a motion to perfect service by publication. He detailed his efforts to locate the uninsured motorist prior to the filing of the action, but submitted no evidence that he had made any attempt to locate or serve the motorist thereafter, by either hiring investigators or using special process serv-

201. 202 Ga. App. 123, 413 S.E.2d 782 (1991).

202. *Id.* at 123, 413 S.E.2d at 783.

203. *Id.* at 124, 413 S.E.2d at 784.

204. *Id.* at 125, 413 S.E.2d at 784.

205. O.C.G.A. § 33-7-11(f) (1992).

206. 198 Ga. App. 727, 402 S.E.2d 519 (1991).

ers.²⁰⁷ The trial court denied the motion.²⁰⁸ The court of appeals explained that service does not in all cases have to be perfected before the statute of limitations expires.²⁰⁹ The timely filing of the action will toll the statute if the complainant proves "that he acted in a reasonable and diligent manner in attempting to insure that a proper service was made as quickly as possible."²¹⁰ The insured failed to prove this in the present case.²¹¹ Therefore, the trial court was justified in denying the motion for publication because of laches.²¹² As a result, the required action against the uninsured motorist never materialized and the insured had no case for recovery against his UMCs.

XVII. REFORMATION

In *Brannen v. Gulf Life Insurance Policy*,²¹³ the insured bought a life insurance policy in 1970 that was to be fully paid-up at age ninety-five. When he lost that policy he applied for a duplicate.²¹⁴ In 1984 he received a policy that had "DUPLICATE" stamped on its front page, but contained a conflicting typewritten annotation providing that the policy "shall take the place of the original and the previously issued policy shall be void."²¹⁵ In 1989 the insured surrendered the "duplicate" policy to the insurer and sought its surrender or cash value. At that time it was discovered that the insurer had negligently included in its "duplicate" policy a table of guaranteed cash values taken from ordinary whole life policies rather than from the old "paid-up policy" that it had issued in 1970. As a result the "duplicate" policy showed higher cash surrender values than the policy it replaced.²¹⁶ The court held that the designation "DUPLICATE" and the typewritten provision created an ambiguity.²¹⁷ Since the typed provisions took precedence over the "DUPLICATE" stamp, the ambiguity had to be resolved by treating the policy as a new policy and not as a mere duplicate of the old policy. Because the new policy related back and provided the same benefits at the same premium

207. *Id.* at 727-28, 402 S.E.2d at 519.

208. *Id.* at 728, 402 S.E.2d at 519.

209. *Id.*, 402 S.E.2d at 520.

210. *Id.* at 728-29, 402 S.E.2d at 520 (quoting *Brown v. Bailey*, 180 Ga. App. 555, 567, 349 S.E.2d 792, 794 (1986)).

211. *Id.* at 729, 402 S.E.2d at 520.

212. The use of "laches" in this context demonstrates that the absorption of purely equitable defenses into the common law is proceeding apace.

213. 201 Ga. App. 241, 410 S.E.2d 763 (1991).

214. *Id.* at 242, 410 S.E.2d at 763.

215. *Id.*, 410 S.E.2d at 764 (quoting the policy).

216. *Id.*, 410 S.E.2d at 763.

217. *Id.*, 410 S.E.2d at 764.

as the old policy, the new policy constituted consideration for the insured's agreement to void the old policy.²¹⁸

Was the insurer entitled to reformation "down" despite its negligent error? The court held that it was.²¹⁹ Despite the statutory exhortation that "[i]f a party, by reasonable diligence, could have had knowledge of the truth, equity should not grant relief,"²²⁰ negligence does not prevent reformation "if it appears that the other party has not been prejudiced thereby."²²¹ Reformation was available in the instant case because, far from causing prejudice to the insured, the insurer's negligence only had the effect of depriving him of an unexpected windfall.²²² Note that the insured might have resisted reformation had he been able to show prejudice in fact. One may, for instance, conceive of situations in which insureds, in reliance upon the higher surrender value options, refrain from surrendering their policies earlier than planned and from obtaining "cheaper" insurance elsewhere.

XVIII. RELEASE AND SETTLEMENT

In Georgia the misnamed and overworked "duty to read" has lost none of its traditional vigor. Insureds are bound by policies and other insurance documents that they have either read or have had an opportunity to read.²²³ The "duty to read" can only be bypassed by a showing that the claimant suffered from a physical "disability which deprived him of the capacity to read and reason."²²⁴ By negating variance claims that are based upon the agent's misrepresentation, the "duty to read" avoids dis-economies because it terminates many a case during the pre-trial stage. It can also work quite harshly, as it did in *McCoy v. State Farm Insurance Cos.*²²⁵ The insured sued his uninsured motorist carrier for breach of contract and fraud in the procurement of a \$3,000 release. He testified that "[the] adjuster tricked him into signing the release by saying that it was

218. *Id.* at 242-43, 410 S.E.2d at 764.

219. *Id.* at 244, 410 S.E.2d at 764.

220. *Id.*, 410 S.E.2d at 765 (quoting O.C.G.A. § 23-2-29 (1982)).

221. *Id.* (quoting O.C.G.A. § 23-2-32(b) (1982)).

222. *Id.*

223. *See, e.g., Epps v. Nicholson*, 187 Ga. App. 246, 370 S.E.2d 13 (1988). Perhaps the leading case reflecting this uncompromising traditional view is *Minsker v. John Hancock Mut. Life Ins. Co.*, 173 N.E. 4 (N.Y. 1930). Strictly speaking, the failure to read does not represent a breach of a contractual obligation exposing the insured to liability. Instead, it represents a forfeiture condition that furnishes a defense to the insurer.

224. *McCoy v. State Farm Ins. Cos.*, 199 Ga. App. 675, 675, 405 S.E.2d 743, 744 (1991). This rule is considerably relaxed when the insured deals with his own agent or fiduciary, particularly in a group insurance integument. *See, e.g., Calhoun v. Kut-Kwik Corp.*, 172 Ga. App. 511, 323 S.E.2d 699 (1984).

225. 199 Ga. App. 675, 405 S.E.2d 743 (1991).

for property damage only"²²⁶ when actually it was an omnibus release for both property damage and personal injuries. He also admitted "that he could and did read some of the forms" and "could have read the release had he seen it."²²⁷ In a later affidavit the insured stated that he had just been discharged from an overnight stay at the hospital when he signed the release and was at that time "tired and groggy" because of medication.²²⁸ The court held that these statements did not show that the insured was at that time suffering from "a disability which deprived him of the capacity to read or reason."²²⁹ Even if the statements did, the "contradictory testimony rule" eliminated them from consideration in the insurer's motion for summary judgment because they conflicted with the claimant's earlier deposition. Thus, the only issue was the claimant's capacity to read and understand what he had signed. The insured's conclusory allegation in the complaint that there was fraud in the factum which he substantiated by specific testimony in his deposition was, *sub silentio*, deemed irrelevant.²³⁰

In *Dickey v. Harden*,²³¹ a passenger was injured when the car in which she was riding was involved in a collision. She brought an action against the owners of the other vehicle. Her husband joined in the action to vindicate his claim for loss of consortium. The trial court denied the defendants' motion for summary judgment, which was based on the affirmative defense that plaintiffs had released their claims by executing an accord and satisfaction with defendants' insurer. As it turned out, plaintiffs had been unaware of any settlement offers, had never signed a release, had not endorsed the settlement check that was made out in their names, and had not received any proceeds from it. Their attorney had simply forged their signatures.²³² The court of appeals held that defendants were entitled to summary judgment.²³³ Plaintiffs had vested their attorney with apparent authority to enter into the settlement on their behalf. Absent a showing that they had communicated to the insurer that the attorney's authority was somehow limited or that the insurer had reasonable grounds for suspecting the attorney's dereliction, they were bound by the attorney's actions.²³⁴

226. *Id.* at 676, 405 S.E.2d at 744.

227. *Id.*

228. *Id.* at 675, 405 S.E.2d at 744 (quoting affidavit).

229. *Id.* (quoting *Mallard v. Jenkins*, 179 Ga. App. 582, 583, 347 S.E.2d 339, 340 (1986)).

230. *Id.*

231. 202 Ga. App. 645, 414 S.E.2d 924 (1992).

232. *Id.* at 645-48, 414 S.E.2d at 925-26.

233. *Id.* at 648, 414 S.E.2d at 927.

234. *Id.* There is some conflict of opinion regarding the apparent authority and "agency power" of attorneys to effect binding settlement with third parties without their clients' consent. See ABA/BNA LAWYERS' MANUAL ON PROFESSIONAL CONDUCT 31: 303-4 (1989). In

The evidence in the record indicated that the insurer had no grounds for suspecting such dereliction.²³⁵ Instead of trying to refute this evidence by relying solely upon the conclusionary allegations and denials in their pleadings, plaintiffs should have “‘set forth specific facts showing that there is a genuine issue for trial’”²³⁶ by affidavits or otherwise. This plaintiffs failed to do.²³⁷

Somewhat surprisingly, plaintiffs also argued that the insurer was responsible for the attorney's actions. By specifically instructing the attorney to submit the settlement papers to his clients and to secure their signatures, the insurer had somehow impressed the attorney into its service as its own agent and was thus “estopped” from relying upon the spurious settlement.²³⁸ The court made short shrift of this curious contention.²³⁹ The attorney had obviously received the papers on his clients' behalf and had remained their agent throughout the settlement negotiations.²⁴⁰

XIX. SUBROGATION AND INDEMNITY

The Georgia No-Fault Act,²⁴¹ although recently repealed, will undoubtedly provide rules of decision in many a case that has yet to be filed or appealed. The Act figured prominently in two cases.²⁴² The first, *United States Fidelity & Guarantee Co. v. Joy Truck Lines, Inc.*,²⁴³ concerned the question whether the Act's limited subrogation rights could be asserted directly against tortfeasors or could only be asserted against tortfeasors' insurance carriers. After being injured in a collision with a truck “weighing more than 6,500 pounds unloaded,”²⁴⁴ the insured col-

Georgia this “power” (as distinguished from actual authority) appears to be quite extensive. See *Davis v. Davis*, 245 Ga. 233, 264 S.E.2d 177 (1980).

235. 202 Ga. App. at 647, 414 S.E.2d at 927.

236. *Id.* at 648, 414 S.E.2d at 927 (quoting *Robinson v. Starr*, 197 Ga. App. 440, 443, 398 S.E.2d 714, 716 (1990)).

237. *Id.*

238. *Id.*

239. *Id.*

240. One may conjecture that the insureds may collect from the insurer at least the amount for which their claim was settled. Even though the attorney may have had apparent authority to receive the check, he had no apparent authority to “forge” the payees' signatures. Moreover, the bank cannot discharge its obligation to its insurer-depositor by making payment to a forger.

241. O.C.G.A. §§ 33-34-1 to -8 (1982) (repealed 1991).

242. A total of nine cases were decided during this survey period. Because of space constraints, only two warrant discussion here.

243. 200 Ga. App. 330, 408 S.E.2d 142 (1991).

244. *Id.* at 330, 408 S.E.2d at 143 (quoting O.C.G.A. § 33-34-3(d)(1) (1982) (repealed 1992)).

lected no-fault benefits from his insurer. Subsequently he brought suit against the tortfeasor and joined his own insurer as an uninsured motorist carrier "because of the alleged involvement of an unidentified third vehicle in the accident."²⁴⁵ Could the insurer, which was now a party to the action, assert a cross-claim against the tortfeasor for subrogation of the no-fault benefits it had paid its insured? The court held that such expedient procedure was unfortunately precluded by the mandate that subrogation rights "shall be determined on the basis of tort law *between the insurers or self insurers involved*."²⁴⁶ This unambiguous language clearly required a "proceeding" between carriers and left no room for the construction that the subrogee urged upon the court, "that tort law controls subrogation proceedings, *procedurally* and substantively," and thus dispensed with "the joinder of carriers whose presence in the case might cause prejudice."²⁴⁷

One may assume that the joinder of a liability carrier in any action against its insured is probably prejudicial, even when such joinder is legal and is at the behest of a party other than the original plaintiff in the tort action. It follows that a no-fault/uninsured motorist carrier in the position of the subrogee in *Joy Truck Lines* may well have to assert its subrogation rights in a separate action.

The second, *Prudential Commercial Insurance Co. v. Michigan Mutual Insurance Co.*,²⁴⁸ concerned the question whether a no-fault insurer is barred from asserting its subrogation rights because it chose not to intervene in an action that was settled with the tortfeasor's insurer before trial. The supreme court, in answering a certified question from the United States Court of Appeals, held that Georgia law did not impose any duty to intervene upon no-fault carriers in torts actions.²⁴⁹ Intervention was not a prerequisite for preserving subrogation rights. Any settlement between the plaintiff and the tortfeasor and the tortfeasor's liability insurer without the consent of the plaintiff's no-fault insurer is only binding upon the parties to the settlement. It does not affect the no-fault insurer carrier.²⁵⁰ The court also held that the subrogee may recover from the tortfeasor's liability carrier all sums that it actually and lawfully paid to its insureds as PIP benefits.²⁵¹ It is not limited to the aggregate statutory amount of "up to \$50,000.00 per person" for optional coverage that the

245. *Id.*

246. *Id.* (quoting O.C.G.A. § 33-34-3(d)(1) (repealed 1992)) (emphasis added).

247. *Id.*

248. 261 Ga. 637, 410 S.E.2d 30 (1991).

249. *Id.* at 638, 410 S.E.2d at 30.

250. *Id.* at 638-39, 410 S.E.2d at 31-32. For statutory change, see *infra* note 274.

251. 261 Ga. at 640, 410 S.E.2d at 32.

insurer must make available to its insured.²⁵² Since subrogation rights "shall be determined on the basis of *tort* law between the insurers or self-insurers involved,"²⁵³ a no-fault subrogee must for this purpose be given the same rights as any other insurer that has made payments to its insured under first-party coverages.

XX. UNINSURED MOTORIST COVERAGE

The litigation-proneness of uninsured and underinsured motorist coverage is a national phenomenon.²⁵⁴ Based on impressionistic reaction rather than jurimetrics, it is safe to say that the litigation spawned by the Georgia Uninsured Motorist Act²⁵⁵ devours at least ten percent of all appellate judge-time devoted to "insurance" cases. The stream of litigation varies in intensity from year to year, but it never becomes a rivulet. It could hardly be otherwise given that about one out of five drivers in this country carries no insurance at all. Even a compulsory insurance regime may be of little help against drivers whose insouciance may cause them to allow their "compulsory" insurance to lapse by nonpayment of premiums after the initial six-month term. Several states have no "physical contact" requirement that the unidentified (and hence presumed uninsured) "hit-and-run" vehicle actually strike the insured vehicle.²⁵⁶

In Georgia a 1983 amendment of the Uninsured Motorist Act dispensed with the "physical contact" requirement whenever "the description by the claimant of how the occurrence occurred is corroborated by an eyewitness to the occurrence other than the claimant."²⁵⁷ The degree of corroboration required has been a contentious issue ever since.

In *Garret v. Standard Guarantee Insurance Co.*,²⁵⁸ the driver of a vehicle that bumped into the rear of the insured's car testified that a vehicle pulled in front of the insured's car " 'which caused her to hit on brakes . . . and that made me hit her.' "²⁵⁹ The court held that this testimony satisfied the statutory mandate because it not only described the existence of the unidentified vehicle, but also implicated the unidentified vehicle as a causal factor in the underlying occurrence.²⁶⁰ It was not necessary that "an eyewitness corroborate each and every detail of the

252. *Id.*

253. *Id.* at 639, 410 S.E.2d at 31.

254. See KEETON & WIDISS, *supra* note 33, § 4.9(a).

255. O.C.G.A. § 33-7-11 (Supp. 1991).

256. For an A.L.R. type discussion of nationwide trends in this regard, see Pin Pin H. Su v. Kemper Ins. Cos., 431 A.2d 416 (R.I. 1981).

257. O.C.G.A. § 33-7-11(b)(2) (Supp. 1991).

258. 201 Ga. App. 251, 410 S.E.2d 806 (1991).

259. *Id.* at 252, 410 S.E.2d at 807 (quoting testimony).

260. *Id.* (emphasis added).

insured's description,"²⁶¹ so long as the eyewitness corroborated the insured's testimony "in its material allegation."²⁶² The fact that the eyewitness may have deviated from that testimony or even contradicted it in some respects would only affect the credibility but not the sufficiency of the corroborating testimony.

By contrast, the eyewitness testimony proffered in *Scott v. Allstate Insurance Co.*²⁶³ failed the "corroboration" test. After a multivehicle accident, the insured brought a John Doe action against the driver of an unidentified truck alleging that a box flying off the truck caused the accident. The two "corroborating" witnesses were able to describe the box in detail but could not say whence it came. This was but circumstantial evidence that did not corroborate the insured's testimony "in its material allegation" as clearly required by statute.²⁶⁴

Attorneys who file automobile tort suits on behalf of their clients are well advised to serve copies of such suits upon their clients' UMCs. This precautionary step seems necessary even when the alleged tortfeasor's being adequately insured is beyond peradventure.

The decision in *Smith v. Allstate Insurance Co.*²⁶⁵ dramatizes that neglecting this service can have dire consequences.²⁶⁶ The insureds "were injured when the bus in which they were riding left the roadway and rolled down an embankment."²⁶⁷ They brought a torts action against the driver, a repair facility, and the motor carrier that owned the bus. They also joined the motor carrier's liability insurer in compliance with the Georgia Code's provisions permitting direct actions against certain liability carriers.²⁶⁸ Twenty-five months after the accident and while the action was pending, the motor carrier's insurer was declared insolvent in its home state. Four months later it was also declared insolvent in Georgia. Thirty months after the accident the insureds finally got around to serving duplicate copies of its tort action upon the UMC.²⁶⁹ Following the rule first enunciated in *Bohannon v. J.C. Penney*,²⁷⁰ the court held that the service was too late to perfect the insureds' claim against the UMC.²⁷¹

261. *Id.*

262. *Id.*

263. 200 Ga. App. 296, 407 S.E.2d 492 (1991).

264. *Id.* at 296-97, 407 S.E.2d at 492-93.

265. 199 Ga. App. 264, 404 S.E.2d 593 (1991).

266. It may also furnish bulletproof grounds for a malpractice suit.

267. 199 Ga. App. at 264, 404 S.E.2d at 594.

268. *Id.*; O.C.G.A. §§ 46-7-12(e), -58(e) (1992).

269. 199 Ga. App. at 264, 404 S.E.2d at 594.

270. *Bohannon v. J.C. Penney Casualty Ins. Co.*, 259 Ga. 162, 377 S.E.2d 853 (1989), *aff'g Bohannon v. Futrell*, 189 Ga. App. 340, 375 S.E.2d 637 (1988); *see also Maximilian Pock, Insurance*, 41 MERCER L. REV. 211, 229 (1989).

271. 199 Ga. App. at 264-65, 404 S.E.2d at 594.

The Georgia Code requires that "a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant."²⁷² Such service must be perfected within the two-year limitation for tort actions. Since its purpose is to alert the UMC to "the existence of a lawsuit in which it ultimately may be held financially responsible,"²⁷³ the limitation begins to run from the date of the accident and not the date when the insured first discovers that the alleged tortfeasor is in fact uninsured or underinsured. That the insureds cannot sue on their contractual cause of action against their UMC until it is determined that there is an uninsured or underinsured motorist involved has no bearing on the UMC's statutory entitlement to notice of the tort action. Such entitlement may, as in the instant case, arise prior to such determination.²⁷⁴

XXI. LEGISLATION

Most of the twenty-six pieces of "insurance" legislation enacted by the General Assembly in its 1992 session are narrowly technical, administrative, or fiscal. Only a few are of more general interest and warrant consideration here.

A purchaser of liability insurance obtains two coverages. The first pays for his financial obligation up to the policy limit and the second provides "free" legal representation. The right to be defended by the insurer is the only widespread form of "Legicare" available in this country.²⁷⁵ Does the duty to defend continue after the policy limit is exhausted? Several jurisdictions, albeit influenced by the vague and inconclusive language in pre-1966 policies, have clearly held that the insurer cannot denude its insured of this valuable protection because the duty to defend is independent of the duty to pay claims up to the policy limits.²⁷⁶ An amendment of the Georgia Insurance Code²⁷⁷ now provides that automobile liability insurers may settle any accident claim that "is or may be covered by an uninsured motorist carrier"²⁷⁸ by agreement with single or multiple claimants. Uninsured motorist insurers may no longer prohibit claimants from settling with liability carriers or require that they obtain permission of their unin-

272. O.C.G.A. § 33-7-11(d) (1992).

273. 199 Ga. App. at 265, 404 S.E.2d at 594.

274. *Id.*

275. Prepaid legal plans have not caught on and are largely found in collective bargaining agreements.

276. See JERRY, *supra* note 95, § 111(e)(2).

277. 1992 Ga. Laws 2514 (H.B. 1676).

278. 1992 Ga. Laws 2514-15, § 1 (adding O.C.G.A. § 33-24-41.1(a) (Supp. 1992)).

sured motorist insurers to do so.²⁷⁹ The amendment specifically provides that such settlement "shall not . . . [a]ffect any duty the liability carrier owes to its insured, *including without limitation the duty to defend.*"²⁸⁰ One may be tempted to conclude that this represents an oblique declaration of public policy that the duty to defend is indeed independent of the duty to pay for liability and thus survives settlement at the policy limits. This may be wishful thinking because the statute merely refers to "any" duty to defend that the insurer might already have and does not impose such a duty. It so happens that the standard 1966 comprehensive automobile policy provides that the insurer "shall not be obligated . . . to defend any suit after the applicable limit of . . . liability has been exhausted by payment of judgments or settlements."²⁸¹ In a similar vein, the 1985 "easy reading" personal auto policy provides that "[o]ur duty to settle or defend ends when our limit of liability for this coverage has been exhausted."²⁸² Unless courts declare such restrictions to be violative of public policy they will have to limit themselves to restricting their scope by narrow construction. It seems, for instance, that a mere tender of the policy limits, as distinguished from an actual payment of the claim, will not terminate the duty to defend under such standard policy language.

Health and accident insurance is rapidly becoming the most regulated branch of insurance. This is exemplified by three amendments. The first revises the Medicare Supplement Insurance Act of 1989²⁸³ by more precisely delineating and adding to the regulatory powers of the Insurance Commissioner, particularly in regard to the promulgation of regulations "necessary to conform medicare supplement policies and certificates to the requirements of federal law."²⁸⁴ The amendment also adds to the penalties for violations.²⁸⁵ The second amendment²⁸⁶ requires accident and sickness insurers to add policy endorsements that cover "annual prostate specific antigen tests" for males "45 years of age or older, or for covered males who are 40 years of age or older, if ordered by a physician."²⁸⁷ The amendment also expands coverage for mammograms, which was already

279. *Id.* (adding O.C.G.A. § 33-24-41.1(c) (Supp. 1992)).

280. *Id.* (adding O.C.G.A. § 33-24-41.1(b)(2) (Supp. 1992)) (emphasis added).

281. KEETON, *supra* note 82, at 658 (Appendix G).

282. KIT, *supra* note 32, at 3.

283. 1992 Ga. Laws 1395 (S.B. 564) (replacing O.C.G.A. § 33-43-1 to -8 in its entirety).

284. *Id.* at 1398 (citing O.C.G.A. § 33-43-3(e) (Supp. 1992)).

285. *Id.* at 1401-02 (citing O.C.G.A. § 33-43-9 (Supp. 1992)).

286. 1992 Ga. Laws 1975 (H.B. 538) (replacing O.C.G.A. §§ 33-29-3.2 and 33-30-4.2 with identically numbered new sections).

287. *Id.* at 1977 (citing O.C.G.A. § 33-29-3.2(b)(2) (Supp. 1992)).

mandated by previous law,²⁸⁸ by introducing a "female at risk" definition that increases the number of insureds eligible for such procedure.²⁸⁹

The third amendment²⁹⁰ requires insurers that underwrite group medical plans covering twenty or more employees²⁹¹ to provide further "continuation" coverage after a member's limited-term "continuation" coverage required under existing Georgia²⁹² and federal²⁹³ law has expired. This "continuation" coverage is available to group members who are sixty years of age or older when their group coverage terminates because of dismissal without fault or because they leave their employment for health reasons.²⁹⁴ Surviving spouses and divorced spouses and their dependent children are also entitled to "continuation" coverage if they are sixty years of age or older.²⁹⁵ Coverage terminates, *inter alia*, when an "eligible group member or the divorced . . . spouse becomes eligible for federal medicare coverage."²⁹⁶ The cost of this coverage may "not be greater than 120 percent of the total of the amount that would be charged if the eligible group member or the divorced or surviving spouse were a current group member."²⁹⁷

The 1960 Unfair Trade Practices Act,²⁹⁸ which was originally only intended to harmonize Georgia law with federal law,²⁹⁹ was extensively revised and restructured. The General Assembly added a new article designated as the "Unfair Claims Settlement Practices Act."³⁰⁰ This article lists fourteen specific prohibited acts.³⁰¹ Any of these acts will amount to an "improper claims settlement practice" if it is committed "flagrantly and in conscious disregard" of the Act or any regulations promulgated thereunder,³⁰² or if it "[h]as been committed with such frequency so as to indicate a general business practice to engage in such conduct."³⁰³

288. O.C.G.A. § 33-29-3.2 (1990).

289. 1992 Ga. Laws at 1977 (citing O.C.G.A. § 33-29-3.2(a)(1) (Supp. 1992)).

290. 1992 Ga. Laws 1969 (H.B. 1202) (adding O.C.G.A. § 33-24-21.2 (Supp. 1992)).

291. *Id.* (O.C.G.A. § 33-24-21.2(f) (Supp. 1992)).

292. *Id.* at 1971 (citing O.C.G.A. § 33-24-21.2(b)(1) (Supp. 1992), referring to O.C.G.A. § 33-24-21.1 (1990)).

293. *Id.* (O.C.G.A. § 33-24-21.2(b)(1), referring to I.R.C. § 4980 (1988)).

294. *Id.* (citing O.C.G.A. § 33-24-21.2(b) (Supp. 1992)).

295. *Id.* at 1972 (citing O.C.G.A. § 33-24-21.2(c) (Supp. 1992)).

296. *Id.* at 1974 (citing O.C.G.A. § 33-24-21.2(f)(3)(D) (Supp. 1992)).

297. *Id.* at 1973 (citing O.C.G.A. § 33-24-21.2(f)(1) (Supp. 1992)).

298. O.C.G.A. §§ 33-6-1 to -37 (1992).

299. 15 U.S.C. § 1011 (1988).

300. 1992 Ga. Laws 3048, 3052 (H.B. 1346).

301. *Id.* at 3053-54 (citing O.C.G.A. § 33-6-34 (1992)).

302. *Id.* at 3052-53 (citing O.C.G.A. § 33-6-33(1) (1992)).

303. *Id.* at 3053 (citing O.C.G.A. § 33-6-33(2) (1992)).

Finally, "The Georgia Tort Claims Act"³⁰⁴ waives Georgia's governmental immunity for torts committed by state agents within the scope of their official duties.³⁰⁵ The Act vests extensive powers in the Department of Administrative Services and empowers it to "formulate and initiate a sound program providing for liability insurance, self-insurance, or a combination of both to provide for payment of judgments and claims."³⁰⁶ The Commissioner of Administrative Services is specifically authorized to "purchase policies of liability insurance or contracts of indemnity insuring or indemnifying the state against liabilities arising under" the new Act.³⁰⁷

304. 1992 Ga. Laws 1883 (S.B. 415).

305. *Id.* at 1886 (citing O.C.G.A. § 50-21-23(a) (Supp. 1992)).

306. *Id.* at 1892 (citing O.C.G.A. § 50-21-33(a) (Supp. 1992)).

307. *Id.* (citing O.C.G.A. § 50-21-33(b) (Supp. 1992)).