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Insurance

by Maximilian A. Pock*

I. INTRODUCTION

The current survey year has again yielded a rich harvest of insurance cases. Georgia appellate courts have handed down more than ninety decisions. Several are cases of first impression in Georgia, while many others have applied or adapted traditional doctrine to a novel factual matrix. These cases merit exegesis and discussion in varying degrees of specificity. Although arising in an insurance integument, the remaining cases concern general substantive law, narrow administrative or technical questions, or pervasive evidentiary and procedural issues. They are better discussed under another title or heading.

Perhaps one impressionistic and general observation is in order. The new wave, “easy reading” policies now percolating through our court system in increasing numbers have, on the whole, kept their promise. They are indeed more user friendly. Their only disadvantage seems to

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1. This Survey includes cases officially reported and made available in print between June 1, 1993 and May 31, 1994.

2. The number of appellate insurance cases increased from an annual average of 60 in the 1960s and 1970s to an average of 90 in the 1980s and early 1990s. However, there were significant fluctuations from year to year with numbers reaching as many as 125.


be that they have, by the stroke of the pen, rendered obsolete the interpretive judicial gloss generated by the gnarled prose found in policies of yore.  

The narrow editorial confines of this Survey have imposed selections, which may appear less inclusive than the subject matter warrants. This is not a random decision, but rather an enforced choice.

To promote continuity, the materials selected will, as far as possible, be discussed under the chapter headings employed in previous years.

II. AGENTS, BROKERS, AND OTHER INTERMEDIARIES

Brokers, who have only a "hunting license" to obtain insurance, are employed by applicants and owe them a confidential or fiduciary duty. Independent agents, who represent two or more insurers, are also employed by applicants and owe them a confidential or fiduciary duty during at least the advisory or negotiation stage until they effect coverage with a specific insurer. Ordinary agents, who represent a single insurer from the outset, owe no such duty. They sell a product and are, in most respects, no different from sales representatives who work for a new car dealership. This means applicants must deal with them at arms' length and exercise prudence on their own behalf. It also means the duty to read is a core modality of the relationship.

This is brought into stark relief by the textbook case of *Hyde v. Acceleration Life Insurance Co.* Plaintiff sued a group health insurer for imputed fraud, alleging he lost his coverage when the insurer's agent "duped him into prematurely cancelling an existing ... policy by promising [him] that he would be covered under a replacement policy." Plaintiff alleged the agent tried to convince him and his

6. One no longer encounters such linguistic monstrosities as "exclusions from exclusions which are in turn part of some primary exclusion." For an example of easy reading policy language, see Martin v. Cotton States Mut. Ins. Co., 210 Ga. App. 32, 32, 435 S.E.2d 258, 259 (1993).


10. *Id.* at 153, 438 S.E.2d at 386.
fellow employees to switch to another insurer by assuring them the new policy would be effective immediately, and they would all be covered for pre-existing conditions because they already represented an actuarily insurable group.\footnote{Id. at 154, 438 S.E.2d at 386.} After the agent made her presentation, she gave each member of the group an application. The application stated there would be no coverage until its acceptance, and applicants answering any of the seven designated health questions in the affirmative would not be approved.\footnote{Id.} The application also contained the customary anti-waiver or modification clause.\footnote{Id.} Plaintiff admitted he signed the application and "entered a 'yes' response to the first health question, affirming that he had undergone open heart surgery."\footnote{Id. at 155, 438 S.E.2d at 387.} His signature appeared directly above the agent's signed certification that she had properly recorded the applicant's responses and advised him not to terminate existing insurance pending notification of acceptance by the new insurer.\footnote{Id.}

The Georgia Court of Appeals upheld a summary judgment for the insurer.\footnote{Id. at 155, 438 S.E.2d at 387.} Even if the agent had been guilty of a gross misrepresentation,\footnote{Id.} the plaintiff had, "‘in the exercise of common prudence and diligence,’”\footnote{Id.} absolutely no right to rely upon it.\footnote{Id. at 155, 438 S.E.2d at 387.}

In the reverse, although cognate, case of \textit{Burkholder v. Ford Life Insurance Co.},\footnote{Id.} the court of appeals held an insurer was not estopped from relying upon an applicant's misrepresentations in regard to his health as a defense, unless the agent taking the application had actual and specific knowledge of the applicant's condition.\footnote{Id. at 909, 429 S.E.2d at 346.} It was not enough that the agent's knowledge was constructive in the sense "that the agent should have known of a medical problem from the applicant's physical appearance or should have inquired further."\footnote{211 Ga. App. 155, 438 S.E.2d at 387 (quoting Godwin v. City of Bainbridge, 172 Ga. App. 290, 292, 322 S.E.2d 733, 735 (1984)).}
III. ASSIGNMENT OF POTENTIAL INSURANCE PROCEEDS

Does an owner of a medical benefits policy who has partially assigned the proceeds to a health care provider, after sustaining an insured loss, continue to have the right to recover such proceeds from the insurer in his own name? In *North American Life & Casualty Co. v. Riedl*, the court of appeals held he did not. Although the assignor's ownership status in the policy remains unaffected by such a partial assignment of a chose in action deriving from it, he no longer has standing to sue solely in his own name or solely as assignor for the use or benefit of the assignee. The real party in interest, who "by the substantive law, has the right sought to be enforced," must now prosecute or join the action.

After becoming aware of the assignment, the debtor-insurer acts at its peril when it pays the assignor. At that point, the debtor-insurer may object, but the action cannot be dismissed "on the ground that it is not prosecuted in the name of the real party in interest." The trial court is enjoined to allow a reasonable time after such objection "for ratification of commencement of the action by, or joinder or substitution of, the real party in interest" before granting a dismissal.

IV. CANCELLATION, NONRENEWAL, AND LAPSE OF INSURANCE

Georgia's procedures for cancellation and nonrenewal of insurance policies operate with the precision of a guillotine because they exact strict compliance. The procedures are lengthy, replete with incorporations by reference, and relatively complicated. It is not surprising insurers occasionally blunder in their endeavors to terminate their contracts. In *Bank of Toccoa v. Cotton States Mutual Insurance Co.*, the insurer made three mistakes in seeking to "divorce" its insured.

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24. Id. at 885, 434 S.E.2d at 822.
26. 209 Ga. App. at 883, 434 S.E.2d at 821 (citing O.C.G.A. § 9-11-17(a) (1993)).
27. Id. (quoting 3A MOORE'S FEDERAL PRACTICE § 17.07 (2d. ed. 1993)).
28. Id.
29. Id. at 884, 434 S.E.2d at 822 (quoting O.C.G.A. § 9-11-17(a) (1993)) (emphasis added).
First, the insurer sent a cancellation notice providing only fourteen days notice instead of the statutory "30 days from the date of mailing or delivery."\(^{33}\) Second, it gave as reason for cancellation that "THIS RISK DOES NOT MEET OUR ELIGIBILITY REQUIREMENTS."\(^{34}\) The insurer tried to cure this in the course of litigation by asserting the reason was shorthand "for reasonable suspicion of criminal activity"\(^{35}\) based on a newspaper report indicating the insured had been arrested on a counterfeiting charge.\(^{36}\) Third, the insurer assumed the original policy was properly cancelled; therefore, it failed to send a timely nonrenewal notice.\(^{37}\) The court of appeals held the fourteen day cancellation notice was fatally defective and rejected the insurer's plea that "the policy should be 'deemed' to be cancelled 30 days after the notice date in such cases."\(^{38}\) The court of appeals also found the stated basis for cancellation was dehors any of the eight authorized reasons for cancellation specifically listed in the statute.\(^{39}\) Conceding, arguendo, that the real basis for cancellation was reasonable suspicion, such cancellation would still be invalid because the statute authorizes cancellation only where there is "a conviction record, criminal or traffic."\(^{40}\) Since the insurer's assumption that it had cancelled the policy faltered on the facts, the insurer should have sent a nonrenewal notice. The failure to do so extended the term of the original policy for another six months.\(^{41}\)

What is the posture of affairs when the insured fails to meet the obligations regarding premium payments or pays by a check which "bounces"?

\(^{33}\) Id. at 390, 439 S.E.2d at 62 (quoting O.C.G.A. § 33-24-44(b) (1990)).
\(^{34}\) Id. (quoting the policy).
\(^{35}\) Id. at 391, 439 S.E.2d at 63.
\(^{36}\) Id. at 390, 439 S.E.2d at 61.
\(^{37}\) Id., 439 S.E.2d at 62.
\(^{40}\) Id. (quoting O.C.G.A. § 33-24-45(c)(7)(C) (1990 & Supp. 1994)).
\(^{41}\) Id. at 393, 439 S.E.2d at 64 (citing O.C.G.A. § 33-24-45(e)(1) (1990 & Supp. 1994)).
In *Boarders v. Global Insurance Co.*, the court of appeals reaffirmed that the answer depends upon whether the policy at issue is a new or renewal policy. A new policy requires a ten-day cancellation notice. A renewal policy, however, requires no cancellation notice and may be voided at its inception. The character of the policy is a matter of construction that is normally a legal question for the judge to decide. Furthermore, in order to qualify as a renewal policy, the policy must be issued by the same insurer and "provid[e] no less than the coverage contained in the superseded policy." In *Boarders*, the facts showed the insured signed a "Renewal Statement" which contained in bold-type a clear provision that "COVERAGE WILL BE NULL AND VOID" if a premium check is returned because of insufficient funds. Since the policy did not etiolate the coverage provided by the original policy, the trial court, in granting a summary judgment for the insurer, was justified in concluding that it was intended to serve as a renewal policy requiring no specific cancellation notice.

Another nonpayment case eluded summary disposition because of its peculiar facts. In *Morgan v. Georgia General Insurance Co.*, the insureds bought a new automobile policy and paid premiums in installments under an arrangement with a premium finance company. They received a renewal offer from the insurer which "stated a total amount for the premium and provided a space for a check mark indicating the insured's desire to finance the premium through" the same premium finance company. The court of appeals held the insured's mailing of the signed and properly marked renewal offer created a bilateral contract committing the insurer to instant coverage in consideration of the promise to pay the premium in installments.

43. *Id.* at 481, 430 S.E.2d at 855.
46. 208 Ga. App. at 481, 430 S.E.2d at 856.
47. *Id.* at 482, 430 S.E.2d at 856 (quoting O.C.G.A. § 33-24-45(b)(2) (1990 & Supp. 1994)).
48. *Id.* at 483, 430 S.E.2d at 857 (quoting the policy).
49. *Id.* The court noted that a change of policy numbers for administrative reasons, a change in insured vehicles, and a change in endorsements that do not otherwise debase coverage are not conclusive indicia or indices of the policy's proper classification. *Id.* They are merely relevant to the determination whether a renewal policy was in fact intended. *Id.*
51. *Id.* at 614, 436 S.E.2d at 783.
52. *Id.* at 615, 436 S.E.2d at 783.
53. *Id.*
The question regarding the acceptance of the offer created a fact issue for the jury, which precluded summary judgment for the insurer.\footnote{54} Proper timing is also an issue pervading cancellation cases. The Official Code of Georgia Annotated ("O.C.G.A.") provides that cancellations for failure to pay premiums when due may be accomplished "by delivering or mailing written notice to the named insured . . . at least ten days prior to the effective date of cancellation."\footnote{55} In *Timely Entertainment International, Inc. v. State Farm Fire & Casualty Co.*,\footnote{56} the court of appeals held that a notice dispatched on the very date the premium became due satisfied the mandate.\footnote{57} A notice sent prior to the maturity date would be premature and thus, qualifies solely as a demand for payment, rather than an effective cancellation notice as required by the O.C.G.A.\footnote{58}

Finally, in *Walton v. Prudential Insurance Co.*,\footnote{59} the court of appeals held that reinstatement of a life insurance policy must strictly conform to the terms of the policy.\footnote{60} The insured and *cestui* had his life policy cancelled for failure to pay premiums.\footnote{61} Seven months later, after a diagnosis of lung cancer, he submitted an incomplete application for reinstatement along with the reinstatement fee and a portion of the first month's premium. The insured died about two months later. Subsequently, the insurer, unaware of his death, returned the application for completion of the health questions.\footnote{62} The application was "honestly" filled out, but his death was not noted.\footnote{63} Did the insurer's retention of the partial premium, together with the fact that it took the insurer nearly four months to resubmit the application for completion, constitute acceptance of the insured's application (offer) by conduct, thus precluding the insurer from denying that the insurance was in force at the date of his death? The court of appeals held it did not.\footnote{64} The original policy provided for reinstatement "within 3 years after termination thereof."\footnote{65}

\footnote{54} Id.
\footnote{55} O.C.G.A. § 33-24-44(d) (1990).
\footnote{57} Id. at 469, 430 S.E.2d 846.
\footnote{58} Id. See also *Stapleton v. Colonial Ins. Co. of Cal.*, 209 Ga. App. 674, 434 S.E.2d 116 (1993) (absent signature of postal clerk is not fatal to proper notice where receipt is indicated by official U.S. Postal Service stamp).
\footnote{60} Id. at 83, 435 S.E.2d at 291.
\footnote{61} Id. at 82, 435 S.E.2d at 290.
\footnote{62} Id.
\footnote{63} Id.
\footnote{64} Id.
\footnote{65} Id. at 83, 435 S.E.2d at 291.
\footnote{66} Id. (quoting the policy).
on the condition the insured furnished evidence of good health and paid the entire premium. Neither of these conditions were met. Furthermore, mere receipt of the application and retention of the accompanying premium does not turn silence into assent in Georgia.

V. CONDITIONAL BINDING RECEIPT

Georgia has not succumbed to the blandishments of the pro-consumer view of conditional binding receipts issued in connection with life and health insurance which holds, almost by rubric, that the insurer is bound to a temporary contract of insurance which is binding as soon as the application is completed and the first premium payment is made.

In World Insurance Co. v. Blalock, the applicant for a health insurance policy received a conditional receipt from the authorized soliciting agent stating there would be no coverage until the insurer was "satisfied that, at the time of completing . . . the application . . . [the applicant was] insurable under [the insurer's] rules . . . 'for underwriting the risk.' This precluded instant insurance and required a determination regarding insurability as a condition precedent to any coverage.

VI. CONFLICT OF LAWS

Until recently, Georgia was a traditional vested rights state in the conflict of laws. The referent and dispositive law on substantive issues was the place of the transaction. In insurance contracts, this

67. Id. at 82-83, 435 S.E.2d at 290.
68. Id. at 82, 435 S.E.2d at 290.
70. A paradigmatic case on this point is Collister v. Nationwide Life Ins. Co., 479 Pa. 579, 388 A.2d 1346 (1978) (the constructive ambiguity between the label "binding receipt", which notes instant coverage, and the text of the receipt is resolved in favor of the applicant even if the text is nonambiguous). There are basically three kinds of binding receipts. The approval type, the satisfaction type, and the unconditional temporary insurance type, which is largely the product of judicial fiat. See Robert M. Jery, Understanding Insurance Law § 33(c), (d) (1991).
72. Id. at 813, 429 S.E.2d at 277 (quoting the policy).
73. Id.
75. Id. at 763, 417 S.E.2d at 673.
was the place where the last act requisite to the formation of the contract occurred (lex contractus). It was not the place where the insurer dispatched the acceptance of the insured's offer (the application), but where the policy was delivered. The place of performance (lex solutionis), while resorted to in non-insurance contracts, was of little avail in insurance contracts because the locus of the contemplated performance normally eluded identification. Georgia eschewed such new dispensations as state interest analysis and the most significant relationship approach pioneered by the Restatement. Where the rhetoric of the new dispensations surfaced in Georgia opinions, usually it was in a factual integument where traditional and "new wave" analyses demanded identical results.

No case appears to have explicitly relied upon the new dispensations. This was changed by Amica Mutual Insurance v. Bourgault. In Bourgault the Georgia Supreme Court ("supreme court") relied explicitly upon the Restatement and out-of-state interpretive authority for the decision.

Georgia residents procured an automobile liability policy on their three cars, which were registered and principally garaged in New York. Although prepared in New York and based on New York rates, the policy was applied for and actually delivered in Georgia. Since New York and Georgia laws were antithetical, the choice of law problem was

76. Id.

77. Id. at 767, 417 S.E.2d at 674-75. See also Pink v. A.A.A. Highway Express, Inc. 191 Ga. 502, 13 S.E.2d 337, aff'd, 314 U.S. 201 (1941) (auto policy: contract is made where policy is delivered); Iowa State Travelers Mut. Ass'n v. Caldwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966) (life policy: contract is constructively made where policy is delivered).

78. Absent a valid choice of law clause or an indication of the place of performance, the dispositive law is that of the place where the policy was delivered, unless application of such law would be violative of Georgia public policy and application of Georgia law would not violate due process. Clabo v. Tennessee Farmers Mut. Ins. Co., 202 Ga. App. 110, 113, 413 S.E.2d 476, 477-78 (1991), overruled on other grounds by Spivey v. Safeway Ins. Co., 210 Ga. App. 775, 778, 437 S.E.2d 641, 645 (1993). Occasionally the place of performance can be ascertained. For example, where the insured activity is centered upon a particular state, the place of performance is that state. Batson-Cook Co. v. Aetna Ins. Co., 200 Ga. App. 571, 572, 409 S.E.2d 41, 42 (1991) (the fact that the policy was issued and to be performed in the same state mooted, as it often does, the question whether the court should apply the lex contractus in its narrow formation-sense, or the lex solutionis).

79. RESTATEMENT (SECOND) CONFLICT OF LAWS § 193 (1967).


82. Id. at 160, 429 S.E.2d at 911.

83. Id. at 158, 429 S.E.2d at 910.
thrown into sharp relief. The supreme court held New York law governed “the validity of and rights created by” the liability policy because it was “the law of the state which the parties understood to be the principal location of the insured risk.”

Although Bourgault constituted a departure from formalistic slot machine conflicts rules, its sweep should not be exaggerated. The decision, while not referring to them explicitly, is compatible with at least two traditional solutions. First, it may represent an application of the lex solutionis because, “in the case of an automobile liability policy, the parties . . . usually know beforehand where the automobile will be garaged.” The place of performance, while usually elusive, can be readily identified. Second, it may simply represent a recognition of party autonomy exercised by conduct and implication rather than by the adoption of an express choice of law clause in the policy itself. The decision may only foreshadow a cautious and selective adoption of those Restatement principles which are rooted in tradition, allowing an orderly evolution of Georgia law, rather than portend a wholesale and indiscriminate displacement of Georgia conflicts rules as they pertain to insurance law.

VII. CONSTRUCTION AND DEFINITIONS

A. Engaged in Any Way in a Car Business

In State Farm Mutual Insurance Automobile Co. v. Seeba, a wrongful death action was brought against the driver of a truck and trailer after a multi-vehicle collision. While admitting the driver was an insured permittee, the owner’s insurer contended the coverage was excluded because the accident occurred while the truck and trailer were “being repaired, serviced or used by any person employed or

84. Id. at 160, 429 S.E.2d at 911.
85. Id. at 160, 429 S.E.2d at 911 (citing RESTATEMENT (SECOND) CONFLICT OF LAWS § 193 (1967)).
86. Id. (quoting RESTATEMENT (SECOND) CONFLICT OF LAWS § 193. cmt. b at 244 (1967)).
87. Id. “It was . . . more reasonable for the parties to expect that New York law rather than Georgia law would be determinative.” Id.
88. Even jurisdictions which at times have followed the Restatement approach have on occasions discrepently rejected the significance of particular connecting factors or contacts that are listed in the Restatement. See, e.g., Tooker v. Lopez, 24 N.Y.2d 569, 579, 249 N.E.2d 394, 400 (1969) (rejecting as irrelevant the place where a guest-host relationship arose or was centered as proposed by RESTATEMENT (SECOND) CONFLICT OF LAWS § 145(2)(d)).
engaged in any way in a car business." The evidence established that the owner left the vehicles with a tractor and farm equipment sales and service company ("car business"), which was to sell them on commission. The company hired the driver in question to move the vehicles to a more suitable display location and to assist in selling the vehicles in return for part of the commission. The accident occurred while the vehicles were moving to the new location. It was also shown that the driver occasionally helped in the company's car business by engaging "in similar transactions on the average of one a year for the last ten years." The driver, however, was principally the owner and manager of a business "engaged in training, showing, and selling horses."

Was the driver, as the focus of the exclusion, engaged in any way in a car business at the time of the collision? The court of appeals held he was not. The language of the exclusion was ambiguous when viewed against the purpose it subserved. "[E]ngaged in any way" arguably encompasses any activity, no matter how fleeting, if it related to "a 'business or job where the purpose is to sell, lease, repair, service, transport, store or park' motor vehicles." The term business, by contrast, denotes a measure of constancy, "an undertaking engaged in with some regularity and for profit and income."

Contra proferentem, coupled with the rule that language placed in exclusions must be narrowly construed against the insurer, required a finding that the driver was only engaged in a secondary activity or hobby, which did not amount to a car business.

### B. Expected or Intended

The 1966 revision of the comprehensive liability policy excludes coverage for "bodily injury or property damage which is either expected

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90. Id. at 329, 433 S.E.2d at 415 (quoting the policy) (emphasis added).
91. Id. at 328, 433 S.E.2d at 415.
92. Id. at 329, 433 S.E.2d at 416.
93. Id.
94. Id.
95. Id.
96. Id. at 329, 433 S.E.2d at 415 (quoting the policy) (emphasis added).
98. Id. at 330, 433 S.E.2d at 417.
99. Id., 433 S.E.2d at 416-17. Even if one concedes the driver was a partner or joint adventurer with the tractor company, his activities would not implicate him in the car business because of their transitory nature. Id., 433 S.E.2d at 417.
or intended from the standpoint of the insured." This simple phrase has proved litigation prone and has led to a good deal of logomachy over such concepts as "wilfulness," "wantonness," and "conscious indifference to consequences." It has also engendered some dispute over the applicability of the tort rule (an actor is presumed to intend the natural consequences of an intended act) or the more narrow contract rule (the exclusion focuses upon the intent to cause harm rather than the intent to perform the germinal act eventuating in harm). The discursive opinion in Reliance Insurance Co. v. Walker County serves to clarify Georgia's stance in this regard.

In Reliance the court of appeals explained the exclusion applies whenever the actor engages in conduct which is intended to cause the very harm which eventuated, or is intended to cause some harm even though the actual harm differs from the one intended, or is accompanied by a state of mind so reckless or consciously indifferent to consequences as to impel the conclusion that the harm must have been "expected or intended." These three scenarios clearly present jury questions based on meticulously worded instructions and generally elude disposition by summary judgment. The burden of proof is on the insurer. The test is subjective, as it focuses on the actor's state of mind. Conduct which is grossly negligent, or the product of bad judgment, does not meet the test.

Generalizations of this kind may falter upon the language of the particular policy at issue. In Stinson v. Allstate Insurance Co., the exclusion in a homeowner's policy stated unambiguously that "[w]e do not cover any bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured

102. 208 Ga. App. at 731, 431 S.E.2d at 702.
103. Id. at 730, 431 S.E.2d at 702.
104. Id. at 731, 431 S.E.2d at 702.
105. Id. at 732, 431 S.E.2d at 703.
106. Id. It is difficult to tell whether Georgia treats expected and intended, terms which are posed in the disjunctive, as synonymous. There is some dispute on this issue in other states. Compare State Farm Fire & Casualty Co. v. Muth, 190 Neb. 248, 207 N.W.2d 364 (1973) (terms are synonymous) with Northwestern Nat. Casualty Co. v. Phalen, 182 Mont. 448, 597 P.2d 720 (1979) (terms do not have the same meaning because they would be redundant).
person." Since there was no reference to the standpoint of the insured, the court of appeals rejected the subjective test and held that "[t]he more universal objective test . . . pertains to this branch of the exclusion." The factfinders were required to determine whether a person in the position of the insured could reasonably expect his act of firing a high-powered hunting rifle through the front door of a house would cause injury, and not whether the insured, as the actor in this melodrama, actually harbored such expectations.110

C. Use . . . of an Aircraft

_Ivey v. First of Georgia Insurance Co._,111 a case of first impression, involved a homeowner who sold a Midget Mustang I airplane and agreed to teach the buyer how to fly it. Because of the single seat design of the plane, the homeowner "remained on the ground and used a handheld radio to communicate with [the buyer] during flight."112 An accident occurred when the buyer landed the plane, and the homeowner faced a liability suit. Was the homeowner covered under his liability floater which excluded claims "'arising out of the . . . use . . . of an aircraft'?"113 The court of appeals held he was not.114 Relying upon analogues drawn from automobile and watercraft accident cases, the court of appeals concluded that the term "use" extended "'beyond actual physical contact . . . at least to the point, beyond physical contact, where control over the instrumentality is easily or reasonably at hand, and particularly when it is still being "utilized",'"115 and was "not ambiguous in the context of this case."116 It thus precluded recourse to _contra proferentem._

The accident arose out of the use of an aircraft because it was "impossible to imagine a circumstance in which a flight instructor could provide ground-to-air instruction without the involvement of an airplane."117 In his trenchant dissent, Judge Blackburn raised some

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108. _Id._ at 180, 441 S.E.2d at 454 (quoting the policy) (emphasis added).
110. _Id._ at 181, 441 S.E.2d at 454.
112. _Id._ at 785, 434 S.E.2d at 557.
113. _Id._ (quoting the policy).
114. _Id._ at 786, 434 S.E.2d at 558.
116. _Id._
117. _Id._, 434 S.E.2d at 557.
puzzling questions about the case. He argued the exclusion was ambiguous because, unlike most other exclusions in the homeowner's policy at issue, it did not specifically refer to the insured. It could arguably apply "to any person's use of an aircraft" or "only to the insured's use of an aircraft." Even if one concedes that this presents an ambiguity, it is difficult to see how the resolution of the ambiguity would have helped the insured. Contra proferentem would have restricted the scope of the exclusion to "the insured's use," which is precisely the activity which eliminated the insured from coverage.

D. While . . . Getting Into

In Major v. Allstate Insurance Co., the claimant "was standing behind her son's car when another car hit her." Was she entitled to uninsured motorist benefits under her son's policy which covered "[a]ny person while . . . getting into your . . . auto with your permission?" The court of appeals held she was not. Curiously, the case was one of first impression because the uninsured motorist coverage at issue was more liberal than that mandated by the Georgia Insurance Code. After an encyclopedic inquiry into the etymological range of the phrase getting into and its congruent definitions, the court of appeals concluded that it meant an act of entry requiring either "direct physical contact between the claimant and the insured vehicle" or "the claimant actually having placed a portion of . . . her body in the vehicle." Physical proximity, the "act of approaching the vehicle," or "preparing to enter the vehicle," are not sufficient.

118. 209 Ga. App. at 786, 434 S.E.2d at 558 (Blackburn, J., dissenting).
119. Id. at 787, 434 S.E.2d at 558.
120. Id.
121. Id. at 788, 434 S.E.2d at 559. Judge Blackburn also faulted the majority for applying a liberal interpretation of use extracted from cases construing coverage provisions thus departing from the rule that coverages are to be broadly construed and exceptions from coverage are to be narrowly construed. 209 Ga. App. at 788, 434 S.E.2d at 559 (Blackburn, J., dissenting).
123. Id. at 805, 429 S.E.2d at 172.
124. Id. (quoting the policy) (emphasis added).
125. Id. at 807, 429 S.E.2d at 174.
VIII. COOPERATION CLAUSES

Insurance policies bristle with cooperation clauses obligating the insured to notify the insurer immediately or as soon as possible of an insured event, to file a timely proof of loss, and to render specified assistance in the investigation of the occurrence. Strictly speaking, such clauses are not promissory in the sense that their breach may expose the insured to a damage suit. They serve as conditions of coverage and are enforced by forfeiture of coverage. Many of the cooperation clauses come well armed with buckler and shield because they are even formulated as express conditions precedent.

In Georgia Farm Bureau Mutual Insurance Co. v. Martin, a truck owned by Day and allegedly driven by Delk hit a bicyclist. A tort action was filed naming Day and Delk as defendants. Although service upon Day was technically defective, he immediately informed his liability carrier of the claim and service. Delk was properly served, but he ignored the action entirely and allowed it to go into default. Two days before Delk's fifteen day grace period to open default expired, plaintiff's counsel sent a copy of the complaint to the carrier by certified mail. Subsequently, Day was properly served and again notified his carrier. Plaintiff's counsel, not having received a receipt for the certified mailing, personally served the carrier with a copy of the complaint. The carrier filed an answer on behalf of Day, but not on Delk's behalf. After an evidentiary hearing, a judgment was entered against Delk. Day was voluntarily dismissed.

The court of appeals held that the carrier was obligated to pay the default judgment against Delk. The court explained that Georgia's statutory mandate for notification does not require the "actor" or additional insured (Delk) to personally notify the liability insurer. The mandate is satisfied if "the insurer receives notice of the suit either from an insured or from a third party." Here, the insurer had notice before the action against the additional insured (Delk) went into default and before the grace period for opening default expired. Yet, "it failed to avail itself of several opportunities to participate in the action.

130. Id. at 237-38, 433 S.E.2d at 316.
131. Id. at 238, 423 S.E.2d at 316.
132. Id. at 239, 433 S.E.2d at 317.
133. Id. at 238, 433 S.E.2d at 316 (citing O.C.G.A. § 33-7-15 (1992)).
134. Id. at 238, 433 S.E.2d at 316-17.
against Delk."\textsuperscript{136} For example, the insurer failed to show Delk was not a permissive user as alleged.\textsuperscript{137} Furthermore, although Delk's failure to elect coverage under the Day policy by active solicitation of such coverage may absolve the liability insurer of any obligation to Delk, it cannot absolve the liability insurer from its obligation to cover Delk's liability to the plaintiff.\textsuperscript{138} Delk, who apparently carried no liability insurance of his own, could not reject the liability coverage available to him under the Day policy and thus elect to denude innocent victims of his negligence of the protection envisaged by Georgia's compulsory liability scheme.\textsuperscript{139} The court of appeals also held Georgia's notification procedures\textsuperscript{140} did not rob the liability insurer of its constitutional rights to due process and equal protection by penalizing it for "the inaction of the additional insured."\textsuperscript{141} The insurer's rights were amply secured because it would have been relieved from paying the default judgment had it not received timely notice from any source.\textsuperscript{142}

Occasionally, cooperation clauses are so clearly breached that one wonders about the perceived need for litigation. In \textit{Aegis Security Insurance Co. v. Hiers},\textsuperscript{143} the owner of a mobile home policy, containing the usual liability floater, learned that his son, the named insured under the policy and occupier of the home, had been involved in a shooting incident. He "learned about the shooting, the day after it happened."\textsuperscript{144} Although the policy required notice "as soon as practicable," neither he nor anyone else bothered to tell the insurer about the event.\textsuperscript{145} The insurer "ultimately learned about the shooting approximately 22 months after it occurred," long after the victim's tort suit was filed.\textsuperscript{146} The court of appeals reversed the trial court's denial of a motion for summary judgement in favor of the insurer and held the

\begin{itemize}
  \item \textsuperscript{136} Id., 433 S.E.2d at 317.
  \item \textsuperscript{137} Id. at 240, 433 S.E.2d at 317-18.
  \item \textsuperscript{138} Id. at 239, 433 S.E.2d at 317.
  \item \textsuperscript{140} 209 Ga. App. at 238, 433 S.E.2d at 317 (citing O.C.G.A. § 33-7-15(c) (1992) and O.C.G.A. § 40-9-103(c)(1991)).
  \item \textsuperscript{141} 209 Ga. App. at 238, 433 S.E.2d at 317.
  \item \textsuperscript{142} Id.
  \item \textsuperscript{143} 211 Ga. App. 639, 440 S.E.2d 71 (1994).
  \item \textsuperscript{144} Id. at 639, 440 S.E.2d at 72.
  \item \textsuperscript{145} Id.
  \item \textsuperscript{146} Id.
\end{itemize}
delay was "unreasonable as a matter of law" because neither insured "offered any excuse for failing to notify" the insurer.

IX. DIRECT ACTIONS AGAINST INSURANCE CARRIERS

Three states and two United States territories have direct action statutes that allow claimants to join alleged tortfeasors and their liability carriers in a single action before establishing the tortfeasors' liability by judgment or settling the case with them. This achieves certain economies in litigation, but it also alerts verdict-happy and perhaps biased juries to the presence of a "deep pocket."

Georgia has a limited direct action statute, authorizing certain motor common carriers and contract carriers to be joined with their insurers. In Johnson v. Woodward, the court of appeals defined the geographical sweep of the statute. A tractor-trailer owned and operated by a Georgia motor common carrier was involved in a collision with a car in South Carolina. The common carrier held a certificate of public convenience and necessity issued by the Georgia Public Service Commission as an entity operating in both interstate and intrastate commerce. The court of appeals held the direct action statute expressly authorized "any person" with "a cause of action" arising under it to sue the common carrier and join its insurer in the same action. Absent any geographic restrictions in the statute itself, there was no reason to infer any legislative intent to preclude such joinder because the claim arose from a tort occurring in a sister state.

Joinder is not a perfunctory matter; it is only available upon a showing that a specific insurer is at least potentially present upon the risk. Two cases illustrate this. In McMillon v. Empire Fire & Marine Insurance Co., a common carrier hired the driver and owner of a tractor-trailer "to haul goods under a trip lease agreement." The driver was involved in an automobile accident, resulting in a direct

147. Id.
148. Id.
149. Id.
150. See JERRY, supra note 71, at § 84(b).
151. O.C.G.A. §§ 46-7-12(e) to -58(e) (1992).
153. Id. at 45-46, 429 S.E.2d at 705.
154. Id. at 42, 429 S.E.2d at 702.
155. Id. at 44, 429 S.E.2d at 704 (construing O.C.G.A. §§ 46-7-12(b),(c),(e) (1992)).
156. 209 Ga. App. at 45, 429 S.E.2d at 705.
159. Id. at 378, 433 S.E.2d at 430.
action by the injured party against the common carrier, and, somewhat inexplicably, the driver's own insurer as the alleged insurer for the carrier. The driver was never named as defendant. The insurer showed the policy was "explicitly denominated as 'Insurance for Non-Trucking Use'" and contained a business use exclusion negating "coverage while the tractor-trailer was leased to another business or used to carry the property of any business." The joinder was improper because the insurer was not potentially present upon the risk.

Wright v. Transus, Inc., by contrast, involved a direct action against a common carrier and its insurer. The action was based on the allegation that one of the carrier's employees negligently injured the plaintiff while driving a tractor-trailer. Whether the operator was an independent contractor or an employee for whose actions the carrier was vicariously liable became a contentious issue at the very outset. The issue precluded disposition by summary judgment and continued as an issue of fact for jury resolution. The carrier's potential nonliability did not invalidate the joinder. The court of appeals determined the sole test was whether the posture of the case implicated the insurer as a party potentially liable under its policy.

X. EXCEPTIONS AND EXCLUSIONS

In Spivey v. Safeway Insurance Co., a sharply divided court reaffirmed that the notorious family or household exclusion in automobile liability policies does not violate Georgia public policy,
despite being invalid in a majority of jurisdictions. The case involved a one car accident in which the owner and sole named insured was injured by the alleged negligence of the driver. The owner had expressly permitted the driver to drive while she remained in the car as a passenger. Her insurer contended the owner was not covered under her own policy, although the driver was admittedly an additional insured under the same policy as a permittee. The reason was the liability portion of the policy excluded coverage "[f]or bodily injury, property damage or death sustained by any insured or any member of the family of an insured residing in the same household as the insured."

Literal application of this exclusion meant the victim's sole recourse was a tort suit against her permittee. The permittee would be forced to pay the resulting judgment out of his own pocket unless he had a liability policy of his own covering him while driving a non-owned automobile. There was no evidence that the permittee carried such insurance. Was this compatible with Georgia's compulsory liability regime which envisages comprehensive financial protection of the public against the highly predictable societal friction damage wrought by the ubiquitous automobile? Five of the nine judges on the court of appeals thought it was. Compulsory insurance statutes do not automatically invalidate all exclusions. Their validity must be analyzed on a case-by-case basis. The sole named insured in this particular case could hardly claim the status of an innocent member of the public who found herself denuded of reasonably expected coverage. She bought the policy and was presumed to be aware of its terms. Furthermore, the public policy against unfairly exposing named insureds to unanticipated liability does not extend to the permissive driver, because he is

171. See e.g., State Farm Mut. Auto. Ins. Co. v. Sivey, 404 Mich. 51, 272 N.W.2d 555 (1978) (exclusio unius prevented expansion of exclusions which were limited to two specific permissible exclusions in the liability insurance statute). See also JERRY, supra note 71, at § 135C. It should be noted that insurers have fared much better in their attempts to retain the household exclusion in their uninsured and underinsured coverages.


173. Id. at 776, 437 S.E.2d at 643 (quoting the policy) (emphasis added).

174. The Highway Safety Institute, in a macabre sort of way, can tell us the number of highway fatalities that will be sustained on given national holidays with almost metronomic accuracy.

175. Id. at 778, 437 S.E.2d at 644-45.


177. Id.
only an additional insured and otherwise a stranger to the policy.\textsuperscript{178} It followed that the exclusion was a matter of party autonomy and not violative of public policy.\textsuperscript{179}

The decision is unfortunate. It is difficult to defend even if one is sympathetic to the legitimate concern of insurers about the risk of friendly or familial collusion, a concern which was not mentioned by the court.\textsuperscript{180} The first prong of the court's rationale represents the duty to read gone amok. Insurance policies, even in their new simple English iterations, are complex documents which are often arcane to lawyers.\textsuperscript{181} Can one rationally expect a car owner, who lets a relative, friend, or acquaintance drive while remaining in the car as a passenger, to know that such a commonplace arrangement may, contrary to all reasonable expectations, potentially denude her of coverage in case of an accident? The second prong apodictically draws distinction between named and additional insureds, according liability protection to the former but not the latter.\textsuperscript{182} This distinction seems spurious when one considers the financial impact of exposing either class of insureds to potential liability may be the same.\textsuperscript{183}

\textit{Moore v. Allstate Insurance Co.}\textsuperscript{184} was decided in a similar vein. The operator of a city garbage truck was involved in a collision with another vehicle and was sued by its driver. The suit also named the City of Atlanta as a defendant. The operator's private automobile insurance carrier denied coverage because the policy excluded "a non-owned auto while being used in any business or occupation of a person insured."\textsuperscript{185}

\begin{footnotes}
\footnotetext{178}{\textit{Id.}, 437 S.E.2d at 645 (overruling that prong of Clabo v. Tennessee Farmers Mut. Ins. Co., 202 Ga. App. 110, 114-15, 413 S.E.2d 476, 478-79 (1991), which held that permittees cannot be denuded of liability coverage under the named insured's policy unless they are beneficiaries of alternative insurance protection).}
\footnotetext{179}{210 Ga. App. at 778, 437 S.E.2d at 645.}
\footnotetext{181}{As a professor, the author is constantly amazed at the degree of ignorance displayed by his own insurance law students about the contents of their policies. They simply know that "they are insured" against a number of vague risks. For a qualified defense of the duty to read, see Ingram, \textit{Should An Insured Be Rewarded For Not Reading The Policy?}, 41 DRAKE L. REV. 705-10 (1992).}
\footnotetext{182}{210 Ga. App. at 778, 437 S.E.2d at 645.}
\footnotetext{183}{It is exactly the same where the permittee carries no policy of his own that is present upon the risk. \textit{See generally} KEETON \& WIDISS, supra note 70, at § 4.7(b)(3).}
\footnotetext{185}{211 Ga. App. at 828, 440 S.E.2d at 683 (quoting the policy).}
\end{footnotes}
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While conceding that the garbage truck was excluded by this language, the plaintiff argued the City of Atlanta carried only $1,000 in liability coverage, which vitiated the exclusion as to him because it derogated from the protection secured by the compulsory insurance statute.\(^{186}\)

The court of appeals made short shrift of this argument by declaring, without explanatory embroidery, that "[h]ere, innocent members of the public are not injured by application of this exclusion, and there is no unfair exposure of the insured to liability."\(^{187}\)

Perhaps the judicial calculus which balances the protection contemplated by the compulsory insurance regime against the needs of party autonomy achieves its most agreeable results when the facts of the individual case remove the injured third party's vulnerability to potential financial disaster. Thus, the named driver exclusion\(^{188}\) and the intentional bodily injury or property damage exclusion\(^{189}\) were both upheld because the injured innocent third party had access to alternative coverage in the form of uninsured motorist insurance furnished under other policies.\(^{190}\)

The remaining decisions do not involve automobile liability policies.\(^{191}\) In *Safeco Insurance Co. of America v. Shawnee Mechanical Contractors, Inc.*\(^{192}\), a general business liability policy purchased by a liquor package store excluded, in pertinent part, coverage for "furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol . . . or liability imposed by [a]ny statute . . . relating to the sale . . . of alcoholic beverages."\(^{193}\)

The court of appeals

\(^{186}\) The claimant involved in the collision was driving a rental vehicle at the time of the collision and carried no insurance. *Id.* at 827, 440 S.E.2d at 683.

\(^{187}\) *Id.* at 828, 440 S.E.2d at 684 (citing Empire Fire Co. v. Dobbins, 205 Ga. App. 700, 423 S.E.2d 396 (1992); Progressive Preferred Ins. Co. v. Browner, 209 Ga. App. 544, 433 S.E.2d 401 (1993)). The authorities for this conclusion do not completely elucidate its rationale. Presumably, the court reasoned the garbage truck driver knew his personal policy would not cover an official vehicle and the claimant was lucky the city carried any general liability insurance at all. Besides, he might have provided alternative insurance coverage of his own.

\(^{188}\) Progressive Preferred Ins. Co. v. J.B. Browner, 209 Ga. App. 544, 433 S.E.2d 401 (1993) (the unnamed driver exclusion was supported by consideration in the form of a reduced premium).


\(^{190}\) 211 Ga. App. at 614-15, 440 S.E.2d at 244; 209 Ga. App. at 546, 433 S.E.2d at 403.

\(^{191}\) Some of the cases dealing with exclusions are subsumed under other headings in this Survey.


\(^{193}\) *Id.* at 166, 433 S.E.2d at 67 (quoting the policy) (emphasis added). See Schroeder v. Georgia Farm Bureau Mut. Ins. Co., 211 Ga. App. 302, 439 S.E.2d 18 (1993) (business use exclusion voided coverage although there was no causal connection between loss and type of excluded activity conducted on the premises).
held this so-called liquor exclusion was neither ambiguous nor violative of public policy, because the General Assembly's imposition of tort liability in connection with certain activities did not equate to a mandate that these activities be covered by insurance.¹⁹⁴

Finally, in Martin v. Cotton States Mutual Insurance Co.,¹⁹⁵ the court of appeals upheld a "rental" exclusion in a homeowners' policy against the contention that it was ambiguous.¹⁹⁶ The policy excluded coverage for "'injury or . . . damage . . . arising out of the rental or holding for rental of any part of any premises.'"¹⁹⁷ It then added that "'[t]his exclusion does not apply to . . . the rental . . . of an insured location . . . in part for use only as a residence, unless a single family unit is intended for use by the occupying family to lodge more than two roomers or boarders.'"¹⁹⁸ The court of appeals translated this language to mean that the "policy clearly excludes coverage when the insured location is rented to others . . . unless only part of the premises is rented to no more than two roomers or boarders."¹⁹⁹ Since the entire residence was rented out to a whole family, the policy provided no coverage. This decision is undoubtedly correct, yet one marvels at the infelicity of draftingmanship which created first a general exclusion, then an exclusion from the exclusion, and finally an exclusion from the exclusion's exclusion. Surely such language, although not unambiguous after syntactical parsing, must complete the rout of any insurance consumer who subjects the policy to casual perusal. Perhaps the newspeak of our new easy reading policies has something to commend it after all!

XI. EXTENDED COVERAGE OR OMNIBUS CLAUSES

In Transportation Insurance Co. v. Allstate Insurance Co.,²⁰⁰ a data processing company permitted its employee to use one of the company owned automobiles for business and personal purposes. The employee "allowed a visiting friend . . . to drive the subject vehicle on an errand to the grocery store for their mutual benefit."²⁰¹ The friend became involved in a collision and was sued for damages. The employer's

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¹⁹⁶. Id. at 32-33, 435 S.E.2d at 259.
¹⁹⁷. Id. at 32, 435 S.E.2d at 259 (quoting the policy).
¹⁹⁸. Id. (quoting the policy) (emphasis added).
¹⁹⁹. Id. (emphasis added).
²⁰¹. Id. at 837, 432 S.E.2d at 260 (emphasis added).
liability policy covered the employer and "[a]nyone else while using with your permission a covered 'auto' you own, hire or borrow." Did this include the permittee's permittee? The court of appeals held it did. The scope of permission dealt with the use to which the vehicle was put and not with the identity of the particular driver. Since the fateful trip at least partially served the employee's own purpose, it qualified as a permitted use that brought the operator of the vehicle within the sweep of the coverage. The court of appeals distinguished DeWorken v. State Farm Mutual Insurance Co. In DeWorken the court of appeals held the permittee's permittee was not covered because the policy required the operation and use of the vehicle to be with the permission of the named insured.

Allstate Insurance Co. v. Wood also involved the application of the popularly named "second permittee doctrine." The owner of a Geo Tracker frequently allowed her friend to use the vehicle for "driving around Dublin and socializing with her friends," but did not specifically permit consumption of alcohol in the vehicle or permit others to drive it. On one occasion, the permittee allowed one of her passengers to take the wheel. The passenger-operator became involved in a collision which injured a third passenger. The permittee "had gotten out of the vehicle just before the collision but did not revoke . . . permission to drive the vehicle." The court of appeals held the second permittee was covered because the policy required only that the use rather than the specific operation of the vehicle be permitted. The court of appeals stated:

[W]here a third person utilizes a vehicle via another person who did have permission from the owner, the fact that such third person had neither express or [sic] implied permission from the owner is irrelevant. So is the fact (that) the third person had no license to drive or was expressly forbidden to drive by the owner.

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202. Id. at 839, 432 S.E.2d at 261 (quoting the policy).
203. Id. at 840, 432 S.E.2d at 262.
204. Id. at 839, 432 S.E.2d at 262 (citing Hemphill v. Home Ins. Co., 121 Ga. App. 458, 174 S.E.2d 251 (1970)).
205. Id., 432 S.E.2d at 261.
207. 208 Ga. App. at 839, 432 S.E.2d at 262.
209. Id. at 662, 440 S.E.2d at 80.
210. Id. at 663, 440 S.E.2d at 80.
211. Id.
Omnibus clauses have undergone an evolution in recent decades. The 1955 Standard Automobile Policy covers any person while using the automobile, provided that the actual use “is with the permission of the named insured.” The 1963 Family Combination Automobile Policy is more convoluted, if not recondite. It “covers any other person using such automobile with . . . permission . . . provided his actual operation or (if he is not operating) his other actual use thereof is with . . . permission, or reasonably believed to be with . . . permission . . . and is within the scope of such permission.” The 1985 new wave “easy reading” Personal Auto Policy covers “[a]ny person using ‘your covered auto,’” but excludes “any person . . . [u]sing a vehicle without a reasonable belief that that person is entitled to do so.”

To this standard language, insurers have often added their own embroidery. Therefore, it is difficult to give generally valid answers to questions regarding second permittees or deviations from the scope of permission. Omnibus clauses will continue to engage courts because of their ongoing linguistic and structural permutations.

XII. HOMEOWNERS’ INSURANCE

The facts in Georgia Farm Bureau Mutual Insurance Co. v. Kephart have a certain soap opera quality about them. They can be stated in the form of a simple law school examination: H and W bought a home that they titled and insured in both their names. Marital difficulties caused W to move out and live with her mother in a trailer. H, who had moved out previously, moved back into the home with his girlfriend “to await the birth of their child.” Prior to her move, W removed H’s name from the homeowner’s policy in partial execution of an otherwise unconsummated informal agreement that H would eventually write over his interest in the home to her. W subsequently obtained a divorce from H. The separation agreement incorporated in the final decree abrogated the informal prior agreement by providing

214. KEETON, supra note 101, at 662 app. H.
215. KIT, supra note 187, at 3 Part A.
216. Id. at 4 Part A.
217. Structural changes occur when language relating to permission is hived from the inclusive coverage clause and placed into a restrictive exclusion. See KEETON & WIDISS, supra note 70, at § 4.7(b)(2). This may impact upon its sweep because coverages are to be broadly construed and exclusions are to be narrowly construed against the insurer. Id.
219. Id. at 424, 439 S.E.2d at 683.
that H was to 'keep the marital abode.' One month after entry of the final decree, the home was destroyed by fire.220 What are W's rights under her homeowners' policy?

The answer is that she has no rights.221 Although W was obviously the only named insured, and arguably had an insurable interest pending her performance of the separation agreement, her move into the trailer prior to the fire terminated, or at least suspended, her coverage.222 The easy reading policy insured residence premises, defined as "the one family dwelling ... where you reside" and further provided that "the residence premises [must be] the only premises where the named insured ... maintains a residence other than business or farm properties."223 Such coverage limitations, although variously but plainly worded, are not uncommon in homeowners' policies. They leave the court no choice but to deny coverage. This result, "although harsh, [is] the result contracted for by the parties."224

What is the status of an innocent insured after a coinsured has violated a policy condition which purports to void the policy? The answer depends on whether the obligations of the insureds under the policy are joint or several. If they are joint, the misdeeds of one insured dooms all the others. If they are several, the misdeeds of one insured has no effect upon the others.

The supreme court, interpreting the 1943 Standard Fire Insurance Policy in Richards v. Hanover Insurance Co.,225 which excluded losses caused by the neglect of "the" insured, held the article "the" was ambiguous.226 As a consequence, the article called for application of contra proferentem, and was construed in favor of the insured and against the insurer, which drafted the language.227 The obligation was thus found to be several.228

220. Id. at 425, 439 S.E.2d at 683.
221. Id. at 426, 439 S.E.2d at 684.
222. Id. at 425, 439 S.E.2d at 684.
223. Id. at 424, 439 S.E.2d at 683 (quoting the policy).
224. Id. (quoting the policy).
225. Id. at 425, 439 S.E.2d at 684. In his concurring opinion, Presiding Judge Beasley stated there was no common law or statutory mandate that insurers expressly warn their insureds that coverage hinged upon the continued existence of specified conditions or direct them to notify their insurers of any changes in such conditions. 211 Ga. App. 426-27, 439 S.E.2d at 685 (Beasley, J., concurring).
227. Id. at 615-16, 299 S.E.2d at 564.
228. Id.
229. Id.
In *Fireman's Fund Insurance Co. v. Dean*, a case of first impression, the court of appeals interpreted a policy condition declaring that 

"the entire policy will be void if... an insured has... intentionally concealed... any material fact." This court concluded that the indefinite article "an," clearly and unambiguously referred to "any" insured and not just to "the" particular actor. This created a joint obligation by all insureds. Misconduct by one could void the policy for all. This, however, did not end the matter. The innocent insured contended the policy language was in derogation of Georgia's mandate that fire policies contain "language at least as favorable to the insured as the applicable portions of the standard fire policy." This meant the policy had to be reformed to change the status of coinsureds from joint obligors to several obligors, consonant with the construction of the supreme court in *Richards*. The court was persuaded and reformed the policy. The case illustrates what is occasionally forgotten: that lawyers have to go beyond the four corners of the policy in order to construe it and determine its validity. The Insurance Code or the Commissioner's Regulations under appropriate delegations, may impart contract terms which cannot be identified by the methods of interpretation and construction applied to garden variety contracts, which give free play to party autonomy.

**XIII. LEGISLATION**

The 142nd Georgia General Assembly generated no pyrotechnics or seismic events comparable with the 1991 repeal of Georgia's No-Fault Statute. Seventy bills and resolutions relating directly or peripherally to insurance law were introduced. Eighteen bills were signed by the governor and became law. If there is any discernible legislative trend characterizing the last decade, it is that accident and health

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231. Id. at 264, 441 S.E.2d at 437-38 (emphasis added).
232. Id., 441 S.E.2d at 438.
233. Id.
234. Id. (citing Sales v. State Farm Fire Ins. Co., 849 F.2d 1383 (11th Cir. 1988)).
236. Id., 441 S.E.2d at 438.
237. Id.
239. The others never left their committees or were only passed by one house. Because many of them are topical and quite in keeping with national trends, they may yet resurface in the near future.
insurance, once the step-child of regulation like title insurance, are becoming interstitially the most regulated branches of insurance law.

Although all passed bills bespeak an orderly evolution of Georgia insurance law and are therefore important, they are generally so narrowly technical as to engage only the attention of the specialist.\textsuperscript{240} Only three pieces of legislation promise to be of some interest to the general practitioner.

The first requires all individual and group or blanket accident and sickness policies issued on or after July 1, 1994, to extend coverage for diagnostic and surgical procedures in connection with certain dysfunctions of the musculoskeletal structure and the correction of specified functional deformities.\textsuperscript{241} The second introduces a procedure for cancellation of insurance policies by insureds.\textsuperscript{242} This is accomplished by returning the original policy to the insurer or by submitting a request to the insurer or its authorized agent “stating a future date on which the policy is to be cancelled.”\textsuperscript{243} Cancellation is effected on the date of receipt of the policy, or the request for cancellation, or the future date specified in the request, whichever is later. The insurer may “waive the future date requirement by confirming the date and time of cancellation in writing to the insured.”\textsuperscript{244} Whenever a “statute, regulation, or contract” prohibits cancellation without notifying specified third parties, the insurer can only accomplish cancellation by mailing or delivering the notice to such third parties, and then allowing at least ten days after mailing or delivery for cancellation to become effective.\textsuperscript{245} The third piece of new legislation is a comprehensive amendment\textsuperscript{246} of Georgia’s domestic relations\textsuperscript{247} and insurance law\textsuperscript{248} designed to comply with the federal Employee Retirement Income Security Act (“ERISA”)\textsuperscript{249} to assure that children have access to accident and health insurance coverage.

\textsuperscript{240} \textit{E.g.}, 1994 Ga. Laws 781 (revising procedures for the conversion of mutual insurers to stock insurers).
\textsuperscript{242} 1994 Ga. Laws 805 (striking O.C.G.A. § 33-24-44.1(a)(1) (1990) and replacing it with a new subsection § 33-24-44.1(a)).
\textsuperscript{243} 1994 Ga. Laws 805 (codified at O.C.G.A. § 33-24-44.1(a)(1)).
\textsuperscript{244} 1994 Ga. Laws 805.
\textsuperscript{245} \textit{Id.} (codified at O.C.G.A. § 33-24-44.1(b)).
\textsuperscript{246} 1994 Ga. Laws 1226.
\textsuperscript{248} \textit{Id.} § 33-24-55 (Supp. 1994).
XIV. LIABILITY INSURER'S OBLIGATION TO DEFEND

Liability insurers are required to defend their insureds against lawsuits alleging covered claims whether or not the suits are “groundless, false, or fraudulent.” This obligation is independent of and potentially larger than the obligation to pay for their insureds' actual liability and it constitutes the only pervasive form of “legicare” we have. The duty is typically, although not exclusively, triggered by the allegations in the complaint. Insurers may face difficult choices at the threshold of litigation, which may only be eased by assuming the defense of their insureds under binding reservation of rights, or by seeking declaratory judgments delineating their obligation, or both. Insurers making a wrong judgment call may face dire consequences. In Georgia, insurers may be liable for the entire judgment, including a default judgment against its insured even though such judgment may be in excess of the liability limits. The extent of their liability is basically a question for the jury.

In Crook v. Georgia Farm Bureau Mutual Insurance Co., the insurer was obligated to defend a homeowner against suits to recover damages for personal injury “caused by an occurrence” which was somewhat circuitously defined as “an accident.” “Accident” was not defined in the policy. After their son was killed in the insured's home, the parents brought a tort suit for wrongful death against the insured homeowner. Was the insurer required to extend a defense, even though evidence indicated that the insured “was a mere bystander while the . . . son committed acts which resulted in his own death?” The court of appeals held the insurer was required to extend a defense. Absent a definition of accident in the policy, the court of appeals resorted to the statutory definition of “accident”, which the legislature defined as “an event which takes place without one's foresight or expectation or

250. KEETON, supra note 101, at 662 app. H (the 1963 revision of the Family Combination Automobile policy).
251. Prepaid general legal insurance plans are virtually unknown. They occasionally surface in collective bargaining agreements. They pose an actuarial nightmare. See generally KEETON & WIDISS, supra note 70, at § 9.1(a).
255. Id. at 614, 428 S.E.2d at 803 (quoting the policy).
256. Id.
257. Id. at 615, 428 S.E.2d at 803.
design. It was clear from the undisputed evidence in the record that "death occurred entirely without [the insured's] intentional 'foresight or expectation or design." Although the subsequent trial might well reveal the parents' tort allegations as "groundless," the insurer must abide by the contract to mount a defense on the insured's behalf. The fact that a formally covered tort claim may be factually unfounded cannot negate the duty to defend.

Dynamic Cleaning Service, Inc. v. First Financial Insurance Co., a case of first impression, in some ways represents an exact reversal of the circumstances surrounding Crook. The insured under a comprehensive general liability policy ("CGL"), was contractually required "to provide after hours cleaning services to a Dairy Queen restaurant." The insured assigned Kemp to do the actual cleaning. When Kemp allowed a former employee of Dairy Queen to enter the restaurant, the employee attacked the restaurant's manager "by stabbing him repeatedly." The manager filed a tort suit against Kemp and the insured. The suit alleged Kemp was negligent in allowing an unauthorized person to enter the restaurant after hours and that the insured was vicariously liable. The CGL policy excluded all coverage "for any claim, demand or suit based on assault and battery, and assault and battery shall not be deemed an accident, whether or not committed by or at the direction of the insured." The court of appeals held that the insurer had no obligation to defend against the artfully crafted allegations in the complaint. Although the facts might have ultimately established direct and vicarious liability for negligence, the allegations clearly established such negligence gave rise to the very claim (damage based on assault and battery) excluded by the policy.

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258. Id. at 614, 428 S.E.2d at 803 (quoting O.C.G.A. § 1-3-3(2) (1982 & Supp. 1994)).
259. Id.
260. Id.
261. Id.
263. Id. at 37-38, 430 S.E.2d at 34.
264. Id. at 38, 430 S.E.2d at 34.
265. Id. (quoting the policy) (emphasis added).
266. Id. at 39, 430 S.E.2d at 35.
267. Id. See Brayman v. Allstate Ins. Co., 212 Ga. App. 96, 441 S.E.2d 285 (1994) (holding that a policy covering bodily injury clearly did not cover slander). The court also imposed a $500 penalty for pursuing a frivolous appeal since appellants had no reasonable basis for anticipating a reversal of the trial court's decision. Id. at 97, 441 S.E.2d at 286.
First party policies invariably contain a “private” statute of limitations. With slight variations in the language employed, they mandate that suits under the policies be brought within one year after “inception of the loss,” or the “loss,” or the “occurrence.” Since this limitation, which is typically phrased as an express condition, is for the benefit of the insurer, it can be waived by the insurer. To determine whether such waiver has occurred, courts must dissect and evaluate the insurer’s conduct preceding and following the expiration of the one year period.

In Shelter America Corp. v. Georgia Farm Bureau Mutual Insurance Co., the insured mortgagee of a mobile home, which had been destroyed by fire on December 24, 1988, did not file suit until October 17, 1990, nearly two years after the loss. The insured contacted the insurer eleven days after the loss and “was informed that... investigation could take up to several months to complete.” Approximately nine months after the insured completed the proof of loss form provided by the insurer, settlement negotiations began. Several communications revealed disagreements in regard to the amount of the loss. About two weeks before expiration of the one-year period, the insurer sent a letter which “set forth the method by which it had calculated the value of the mobile home” and stated that “nothing in this letter is intended as a waiver of any right... to insist upon strict compliance with all contractual terms and conditions, including any applicable limitations.”

All prior communications contained identical disclaimers. Two weeks after expiration of the one-year period, the insurer finally informed the insured that its claim was time-barred.

The court of appeals sided with the insurer. There was nothing in the communications “designed to lull the claimant into a false sense of security so as to constitute estoppel by conduct.” The insured was alerted to the fact (at all times) that its proper recourse in case of disagreements was a timely suit.

269. Id. at 258, 433 S.E.2d at 141.
270. Id. at 259, 433 S.E.2d at 141.
271. Id. (quoting the letter at issue).
272. Id.
273. Id., 433 S.E.2d at 142.
275. Id.
until settlement negotiations actually began. Even in the best of circumstances, the tolling may occur only during such negotiations, and then only if they are attended by the waiver conduct which creates an estoppel against the insurer. This was obviously not the case in Shelter. The court also dismissed the contention that the insured’s contractual rights to “demand an appraisal of the loss” in case of disagreement somehow survived the one year limitation. Even if the insurer had made a timely demand for such appraisal, “the object of [such] appraisal would be to determine the amount of loss, and . . . any suit to collect any appraised amount would be barred by the same contractual limitation provision.”

XVI. LOSS PAYABLE ENDORSEMENT

Rice v. State Farm Fire & Casualty Co. was a case of first impression in Georgia. Burglars relieved a store owner of merchandise located on the premises. Acquisition of the merchandise by the store owner was floor plan financed by a lender, which, at the time of the burglary, had a security interest in the merchandise covering the owner’s indebtedness. A business policy designated the owner as named insured and the lender as loss payee “as interest may appear.”

The lender subsequently sued the owner as a creditor “pursuant to the terms of its floor plan security agreement . . . to obtain compensation as to certain inventory missing and not paid for by” the owner. The suit was settled and the lender signed an omnibus release discharging the owner from all manner of liability. Did this release authorize the owner to recover the entire cash value of the stolen merchandise (from its insurer)? The court of appeals held it did not.

The settlement and release focused on the owner’s liabilities and not upon those of the insurer, whose obligation towards the lender loss payee became fixed the moment the casualty occurred. It could not be tortured into a relinquishment of the lender’s security interest in the stolen property, or into an assignment of its interest as a loss payee.

276. Id. at 260, 433 S.E.2d at 142.
277. Id.
278. Id. at 259, 433 S.E.2d at 142 (quoting the policy).
279. Id.
280. Id. at 260, 433 S.E.2d at 142 (quoting the policy).
282. Id. at 170, 430 S.E.2d at 79 (quoting the policy).
283. Id. at 166, 430 S.E.2d at 76.
284. Id. at 170, 430 S.E.2d at 79.
285. Id. at 171, 430 S.E.2d at 79.
286. Id.
This was buttressed by the fact that the policy provided that assignments of interests under it would not be binding upon the insurer unless its consent was "endorsed on the policy." No endorsement was ever obtained. Absent an effective assignment, the owner was limited to a recovery of the jury-determined actual cash value of the stolen property, as reduced by the value of the lender's insurable interest in the property. Allowing the owner to recover for his own interest and that of the lender, would violate Georgia's policy "prohibiting windfall and double recovery."

XVII. MUTUAL INSURANCE COMPANIES

In Boynton v. State Farm Mutual Automobile Insurance Co., an insured brought "a putative class action" against an insurer, in which he urged upon the court a truly novel argument. The insured contended the use of the word "mutual" in the insurer's name and in its advertising, coupled with the charging of a membership fee and a statement in promotional materials that it "will pass along to policyholders any savings resulting from efficient operations," created a contractual duty to return all income in excess of amounts required for payment of insurance claims and operating expenses. The court of appeals had no difficulty in skewering this ingenious argument. The policies themselves stated that policyholders were only entitled "to receive dividends the Board of Directors in its discretion may declare" and/or "to share in the earnings and savings of the company in accordance with the dividends declared by the Board of Directors." This negated any claim based on breach of contract, conversion, fraud, or injunctive relief under the Uniform Deceptive Trade Practices Act.

XVIII. OTHER INSURANCE—PRIMARY AND EXCESS CARRIERS

When A drives B's car, two liability policies may be present upon the risk. The same may be true when A drives his own car in the business of B, who may be vicariously liable for A. If each policy contains an

287. Id. at 170, 430 S.E.2d at 78.
288. Id. at 171, 430 S.E.2d at 79.
289. Id.
291. Id. at 756, 429 S.E.2d at 305.
292. Id., 429 S.E.2d at 306.
293. Id.
294. Id. at 757, 429 S.E.2d at 306.
295. Id. (quoting the policy).
296. Id. at 757, 429 S.E.2d at 306 (citing O.C.G.A. §§ 10-1-372 to -373 (1994)).
unadorned "other" insurance clause, the two carriers simply prorate in accordance with their respective liability limits. This, however, is an unlikely event because insurers try to elude proration by elaborate and specific excess and escape clauses that limit their liability or avoid it all together. Determining which policy is primary and which is excess seems to depend on which policy is read first.

One way of cutting this Gordian knot, which is not alien to Georgia, is to hold that irreconcilable excess/escape clauses nullify each other and ignore them. This restores simple proration. Another approach is to use some mechanical formula for assigning primary status to one of the policies. In Georgia, discrete but result oriented reconciliation on a case-by-case basis has produced a state of affairs in which the policy insuring the vehicle’s owner is generally classified as the primary policy, and the other is treated as excess or entirely escapes.

As illustrated in Georgia Mutual Insurance Co. v. Rollins, Inc., sometimes reconciliation is not necessary. A termite extermination company employee was involved in an accident while driving his own insured car in the scope of his employment. His policy covered him as the named insured and also covered his employer as the additional insured in connection with vicarious liability. The policy provided a $15,000 liability limit and obligated the insurer to defend its insureds. It also cautioned the employer it was only "excess insurance over any other valid and collectible insurance." The employer carried a

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298. Id. at 248, 205 S.E.2d at 874.
303. Id. at 745, 434 S.E.2d at 583. The omnibus clause typically covers "any other person or organization not owning or hiring the automobile, but only with respect to his or its liability because of acts or omissions of an insured." 1963 Family Combination Automobile Policy. Coverage A, Persons Insured (a)(3), (b)(3); KEETON; supra note 101, at 662 app. H.
304. 209 Ga. App. at 746, 434 S.E.2d at 584 (quoting the policy) (emphasis added).
general liability policy covering nonowned vehicles used by employees. The policy “provided for a ‘self-insured retention’ amount of $25,000” and limited liability to amounts in excess of the self-insured retention. There was no evidence the employer was a formal self-insurer, which turned the self-insured retention clause into a simple deductible.

The policy also required the employer to provide its own defense at its own expense. When the employee’s carrier refused to extend a defense to the employer as additional insured, the employer hired its own attorney who worked with the employer’s insurer in conducting the defense. After the tort suit against the employee and his employer was settled, the employer sued the employee’s insurer “to recover attorney fees and expenses in the liability suit, and also to recover damages for the alleged bad faith refusal to defend.” The trial court granted summary judgment in favor of the employer. The court of appeals sustained the trial court’s judgment because it was pellucidly clear that the language of the two policies meshed and required no reconciliation.

The employee’s $15,000 policy provided primary coverage. It could not masquerade as excess coverage because the employer’s policy provided no “valid and collectible” insurance until the $25,000 threshold was reached.

XIX. PROFESSIONAL MALPRACTICE POLICIES

Although generalizations are risky, it is fairly safe to state that malpractice liability policies appear in two basic iterations. The “occurrence” policy requires the liability causing event to occur during the policy term, even though the actual claim is not made until after the expiration of the term. The “claims-made” or “discovery” policy requires the liability causing event to be discovered and result in a claim filed during the policy term, even though it arose before the term. The occurrence policy is prospective. It carries a long tail and confronts the insurer with an actuarial nightmare. Given the lengthening of statutes of limitations applicable to medical malpractice, the increase in judge
made tolling events, and unpredictable inflationary trends, the potential exposure to liability may bear no rational relationship to the premiums collected. The discovery policy is retroactive, allowing premiums to be set in line with past experience. Therefore, it is no surprise that the discovery policy has become popular with insurers and has partially supplanted the "occurrence" policy.

Both types of policies surfaced in Brown v. Hitch\(^{313}\) in an unusual and collateral litigation context. A professional corporation supplying physicians to hospital emergency rooms entered into an employment contract with the plaintiff. The contract provided the physician "shall purchase a professional liability insurance policy . . . and insure that said policy shall be in effect at all times during the terms of the Agreement."\(^{314}\) The contract required the employer to reimburse the plaintiff for the cost of the premiums paid, but it did not specify the particular type of policy to be purchased. The physician obtained a discovery policy, which furnished coverage until he left his employment after about three years. He was reimbursed for premiums paid during this time.\(^{315}\) In anticipation of terminating the employment contract, the plaintiff purchased a separate tail end or occurrence policy to cover future claims arising from liability creating events, which might have occurred during his employment.\(^{316}\) The policy became effective upon termination of his employment, the same time coverage under the original policy ceased. The employer refused to reimburse the cost of the new policy.\(^{317}\)

Was the employer in breach of contract? The court of appeals held he was not.\(^ {318}\) Both parties understood the insurance requirement of the contract was imposed because hospital staff rules mandated individual emergency services physicians carry their own malpractice insurance.\(^ {319}\) Therefore, the employer was only interested in and willing to pay for such insurance as the plaintiff carried while providing services to the hospital.\(^ {320}\) This common understanding was further corroborated by the plaintiff's subsequent election to purchase a discovery policy.\(^ {321}\) Presumably, the plaintiff would have had a valid reimburse-


\(^{314}\) 208 Ga. App. at 784, 431 S.E.2d at 751 (quoting the employment contract).

\(^{315}\) Id. at 785, 431 S.E.2d at 751-52.

\(^{316}\) Id., 431 S.E.2d at 752.

\(^{317}\) Id.

\(^{318}\) Id. at 786, 431 S.E.2d at 752.

\(^{319}\) Id.

\(^{320}\) Id.

\(^{321}\) Id.
ment claim if he had procured an occurrence policy at the outset. This would have met the contract's requirement for a policy effective during the term of employment and would have covered him prospectively. As an uninformed insurance consumer, he should not be faulted for his understandable lack of information, which may be shared by even experienced attorneys who seek protection from liability for malpractice. 322

XX. RESTITUTION

Does an insurer, that has made a payment to a health care provider on the mistaken factual assumption that the patient was covered, have a claim for restitution against the health care provider? 323 The answer is a lawyer-like "yes and no." In Time Insurance Co. v. Fulton-DeKalb Hospital Authority, 324 a group health insurer paid Grady Hospital nearly $200,000 on behalf of a patient for medical treatment actually rendered. The insurer subsequently discovered that the patient had been convicted of setting the fire which caused his injury. The patient's injury arose from the commission of a felony and was therefore specifically excluded from coverage. Since the payment was made under an innocent mistake of fact, the insurer contended Grady would be unjustly enriched if allowed to keep the money. 325 After surveying Georgia and "instructive" out-of-state cases, the court of appeals concluded the record revealed no circumstances indicating unjust enrichment. 326 The court held, "[i]t is clear that Grady would be prejudiced by refunding the payment and that it in good conscience may retain payment for medical services rendered." 327 The result would be

322. In Gyler v. Mission Ins. Co. and Sparks v. St. Paul Ins. Co., the attorneys insured under legal malpractice policies won their cases after protracted litigation which might have been averted by a more discriminate and informed selection of the policies at issue. 10 Cal. 3d 216, 514 P.2d 1219 (1973); 100 N.J. 325, 495 A.2d 406 (1985).
323. The case did not involve any rights the insurer might have against the patient by bestowing a benefit upon him in misreliance upon a unilateral mistake. The law of restitution was literally hand-crafted by Lord Mansfield in Moses v. Macferlan (Macphelan), K.B. 1760, W. BL. 219, 96 Eng. Rep. 120 (K.B. 1760). Burr 1005, 97 Eng. Rep. 676 (K.B. 1760).
325. Id. at 36, 438 S.E.2d at 152.
326. Id. at 37, 438 S.E.2d at 152.
327. Id. at 36, 438 S.E.2d at 151 (emphasis added). See generally DAN B. DOBBS, HANDBOOK OF THE LAW OF REMEDIES § 11.9 (1973).
different if Grady had been alerted to the mistake before or at the time payment was made. This lapidary statement, even when viewed against the discrete authority relied upon, is hardly self-elucidating. The court did not explain how refunding the money would be prejudicial to the recipient.

Does it make any difference whether the money received is still available, or whether it has already been expended? Does it make any difference whether the services would have been furnished at any rate, or whether Grady would not have furnished the services but for the payment (detrimental reliance)? Are either or both of the above circumstances simply presumed as a matter of common sense? The precise answer may have to await further fine tuning.

XXI. STATUTORY PENALTIES AND ATTORNEY FEES

Georgia law provides:

[in the event of a loss which is covered by a policy of insurance and the refusal of the insurer to pay the same within 60 days after a demand has been made by the holder of the policy and a finding has been made that such refusal was in bad faith, the insurer shall be liable to pay such holder, in addition to the loss, not more than 25 percent of the liability of the insurer for the loss and all reasonable attorney's fees for the prosecution of the action against the insurer.]

This requires not only a finding that the plaintiff has "won" the case, but also a separate finding that the insurer was in bad faith in not defending the claim.

Speaking from general experience acquired in writing this survey for over a quarter of a century and without the aid of jurimetric inquiry, the author may accurately conclude that insureds are rarely vindicated when they assert claims for attorney fees and bad faith penalties. The reasons are pluriform. Insureds may simply lose because they have no underlying claim, or because they are unable to establish the insurers' procrastinations or denials were in bad faith or stubbornly

328. 211 Ga. App. at 36, 438 S.E.2d at 151-52.
Yet, one cannot conclude from the high casualty rate amongst prayers for bad faith penalties the statute has failed its intended purpose. Any such conclusion would ignore the ineluctable fact that many attorneys tend to add prayers for such relief almost as a matter of routine. From the vantage point of the insurer, the "best" case for fending off such claims is a showing that the particular issue involved had never been decided in this state. A showing that there is a persistent conflict in the evidence, or that there is an arguable cleavage of authority in Georgia precedents, is of nearly equal utility. One could, of course, penalize all insurers for making wrong judgment calls in good faith. Yet even the most avid consumer advocates do not demand that insurers defend all cases at their own peril. Such policy would, aside from its doubtful constitutionality, simply push our premiums into the stratosphere.

Perhaps the time has come to rethink our traditional litigation cost allocation rule, which requires winning plaintiffs to defray the expense of their legal representation. In addition to rules penalizing the insurer's conduct, the law might simply provide that losing insurers who make wrong judgment calls in denying or defending claims are liable for the winning plaintiffs' reasonable attorney fees. This would be particularly useful in connection with certain claims, such as relatively small tort claims or general contract claims, in which contingent fee contracts are uncommon. If one concedes that both parties are entirely innocent, it is nevertheless the insurer that set into motion events (denial of claims and thus necessitating litigation) which have caused the loss (the insured's attorney fees). When confronting a situation where one innocent party caused a loss to another innocent party, the legal system normally shifts the burden of the loss to the actor.

There is also ample precedent for reallocating attorney fees in this manner in connection with special litigation governing an increasing number of legal scenarios. It is also routine practice in administering equitable remedies. It is already, nolens volens, the law in Georgia in those areas where federal law preempts local law. Thus, under the Employee Retirement Income Security Act ("ERISA"), Georgia may not apply its penalty statute, but may only award attorney fees as provided


334. About 15 to 20% of all appellate cases involve claims for statutory penalties and attorney fees.


by ERISA itself. Obviously such cataclysmic change would require initiatives which may never commend themselves to the General Assembly.

XXII. UNINSURED AND UNDERINSURED COVERAGE

Litigation generated by the Georgia Uninsured Motorist Act swallowed up more than ten percent of all appellate judge time devoted to insurance cases. This litigation proneness extends beyond Georgia and is a well-documented national phenomenon.

A. Phantom Cars and Hit-and-Run Vehicles

The 1963 Family Combination Automobile Policy and the standard 1985 Personal Auto Policy, for obvious evidentiary purposes, require physical contact between the insured or the insured's vehicle and the hit-and-run vehicle, the operator or owner of which cannot be identified. Some states mandate coverage for hit-and-run vehicles without explicitly imposing a physical contact requirement. Whether the term hit-and-run standing by itself necessarily denotes physical contact has become a contentious issue resulting in cleavages of authority. Several courts have held that hit-and-run requires no physical contact because it "is merely a shorthand colloquial expression that is designed to describe a motorist who has caused ... an accident and flees the scene." Hence, all policies requiring physical contact are considered in derogation of the statutory mandate. Georgia, in a 1983 amendment of the Uninsured Motorist Act ("UMC"), explicitly dispensed with the physical contact requirement whenever "the description by the claimant of how the occurrence occurred [sic] is corroborated by an eyewitness to

339. Nine uninsured motorist cases were decided during this survey year. Some are discussed under other headings in this survey. The stream of litigation varies somewhat from year to year but never becomes a rivulet.
340. See KEETON & WIDISS, supra note 70, at § 4.9(a).
341. KEETON, supra note 101, at 664 app. H.
342. KIT, supra note 187, at 6 PART C.C.3 ("a hit-and-run vehicle whose operator or owner cannot be identified and which hits ... you") (emphasis added).
343. Id.
the occurrence other than the claimant. In the typical case arising under this amendment, the claimant does not want for a description of the occurrence, but lacks the requisite corroboration.

In Langford v. Royal Indemnity Co., this fact pattern was curiously inverted. The claimant was injured when she ran into a road curbing in an attempt to evade a collision with a truck which suddenly swerved into her lane. The truck driver stated to a police officer on the scene that an unidentified Buick stopped in front of his truck causing him "to come to an immediate stop, that [his] truck bumped the Buick and, that in the process of stopping, the truck trailer slid into the [claimant's] lane."

When the claimant, who had not personally seen the phantom Buick, became aware of this new posture of affairs, she amended her complaint against the trucking company by adding a "John Doe" defendant and serving her uninsured motorist carrier. At this point her pleadings went awry. After alleging her claim against the trucking company with reasonable particularity, she vaguely added that the truck driver may have swerved into [her] lane to avoid a vehicle driven negligently by an unknown third-party driver as alleged by the [truck] driver in the accident report. Was this a "description by the claimant of how the occurrence occurred" which could be corroborated by direct evidence of its eyewitness, the truck driver? The court of appeals held it was not. The claimant's new "averment constituted nothing more than a speculative allegation of how the occurrence may have occurred." This was not cured by the general averment in her prayer for relief that some unspecified negligence by "John Doe" caused the chain reaction which resulted in her mishap.

Since there was no positive description of the occurrence, there was nothing to be corroborated, and the court of appeals determined that

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347. Id. § 33-7-11(b)(2) (emphasis added).
350. Id. at 128, 430 S.E.2d at 101 (emphasis added).
351. Id. at 134, 430 S.E.2d at 101. A claimant must first obtain at least a nominal judgment against the known uninsured driver or file a "John Doe" action against the unknown (and hence presumed uninsured) driver before proceeding against the uninsured motorist carrier. State Farm Mut. Auto. Ins. Co. v. Noble, 208 Ga. App. 518, 520, 430 S.E.2d 804, 806 (1993).
352. 208 Ga. App. at 133, 430 S.E.2d at 105 (quoting the pleadings).
353. Id.
354. Id.
355. Id.
summary judgment in favor of the UMC was warranted.\footnote{356} The court of appeals added, parenthetically, that the claimant could not contend there was any indirect contact with the phantom vehicle because such contact which may have occurred was only between the phantom vehicle and the truck, without any further contact between the truck and her vehicle.\footnote{357}

The only consolation one can offer the claimant is she would probably have lost her case under any circumstances, even if she had adopted the truck driver's statement as her description of the occurrence in the pleadings. Obviously her own testimony in the subsequent trial would not have implicated the phantom vehicle which she never saw. In the absence of other witnesses fleshing out her description of the occurrence, she would have faced the same problem.\footnote{358} Surely the court in \textit{Langford} did not suggest that she could base her description solely on the truckdriver's testimony and then rely upon the same testimony for its corroboration.\footnote{359}

The contact/corroboration test also bedevils many claimants who have a great deal of evidence negating any suspicion that their claims may be feigned. In \textit{Fisher v. Clarendon National Insurance Co.},\footnote{360} a case that could serve as a contemporary cultural pastiche, the driver of a truck and trailer was suddenly fired upon and hit by occupants of an unidentified sports car who had been harassing him for some time. The bullets damaged his cab and caused him severe injury. The driver managed to stop the rig on the side of the road, dismount, and flag down a motorist whom he asked to call the police. He then staggered to a house and told his story to the owner who "called authorities and attempted to stem the bleeding until they arrived."\footnote{361} The court of appeals held the driver was not covered by his uninsured motorist rider.\footnote{362} Res gestae evidence as to his condition immediately after the accident was not corroboration. Being hit by a bullet fired from a phantom vehicle was not the same as being hit by the vehicle itself, even

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\begin{itemize}
\item 356. \textit{Id.} at 133-34, 430 S.E.2d at 105.
\item 357. \textit{Id.} at 130, 430 S.E.2d at 102 (citing State Farm Fire Ins. Co. v. Guest, 203 Ga. App. 711, 417 S.E.2d 419 (1992)).
\item 359. See \textit{Bell v. Coronet Ins. Co.}, 197 Ga. App. 211, 398 S.E.2d 242 (1990). The claimant's description, based on her own observation, need not be perfect, but it has to suggest, at the very least, that a phantom vehicle was implicated as a causal factor in the occurrence. \textit{Atlanta Casualty Ins. Co. v. Crews}, 197 Ga. App. 48, 397 S.E.2d 466 (1990).
\item 361. \textit{Id.} at 712, 437 S.E.2d at 345-46.
\item 362. \textit{Id.} at 713-14, 437 S.E.2d at 347.
\end{itemize}
if one concedes launching projectiles from an uninsured vehicle qualifies as a use of the vehicle. 363

Finally, in Murphy v. Georgia General Insurance Co., 364 plaintiff contended he needed no eyewitness corroboration of his claim that "a pipe fell from the bed of [an] unknown truck, struck the windshield of his vehicle and caused him to lose control . . . ." 365 He was also out of luck. The court of appeals held that a collision with a phantom vehicle's cargo was not the same as a collision with the vehicle itself or with one of its components. 366

B. Service Upon the Uninsured Motorist and the UMC

Attorneys who file automobile liability suits on behalf of their clients must do so within two years of the date of the accident. 367 They are also well advised to involve their clients' UMC's at the earliest possible moment, even in those cases where the alleged tortfeasor appears to carry sufficient liability coverage to pay for the damage and there is no doubt about the liability carrier's solvency. The procedure is disarmingly simple. It is satisfied by serving a copy of the action upon the UMC as though the UMC were actually named as a party defendant. 368 Such service must be perfected within the time required by law for service upon the alleged tortfeasor. 369 Timely filing coupled with late service, either upon the tortfeasor, the UMC, or both, may have dire consequences. 370 Service after the expiration of the statute of limitations relates back to the time of filing and tolls the statute of limitations only if the plaintiff can prove "that he acted in a reasonable and diligent manner." 371

Whether the plaintiff has done so is largely committed to the discretion of the trial judge, whose finding of laches will rarely be disturbed on appeal. 372 In Walker v. Georgia Farm Bureau Mutual

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363. Id.
365. Id. at 502, 431 S.E.2d at 147.
368. Id. § 33-7-11(d) (1992 & Supp. 1994).
370. The consequences include a possible exposure to a malpractice suit for the attorney involved.
372.
Insurance Co., the trial court held the doctrine of laches was applicable when the plaintiff waited until one month before expiration of the two year limitation to file his action against two alleged tortfeasors and serve a copy of the action upon his UMC. "He then waited until 40 days after the statute had expired to file a motion for service by publication, claiming he could not find the culprits despite the efforts of a private detective whom he engaged for that purpose. Service remained unperfected. The court of appeals upheld the trial judge's finding of laches and his grant of summary judgment for the UMC.

In Peoples v. State Farm Mutual Automobile Insurance Co., plaintiff in an automobile tort action decided to add his UMC as a party. He filed a motion to this effect with the trial court about two weeks before the expiration of the statute of limitations. The motion was denied, and the UMC was not served with the amended complaint until more than two months after the expiration of the statute. Plaintiff claimed he had been informed that he could not receive timely hearing on the motion because the next motion day was not until after expiration of the statute. The court of appeals held the decision to name the UMC as a defendant had nothing to do with the UMC's entitlement to timely service. Plaintiff should have served a copy of the original action upon his UMC. On a parity of reasoning with Walker, the court of appeals again upheld the trial's judge's finding of laches.

C. Umbrella Uninsured Coverage

In Sun Insurance Office, Ltd. v. Thibadeau, the claimant's ingenious attempts to secure underinsured coverage under a homeowners umbrella and personal excess liability policy, although unsuccessful, deserve an "A" for effort. The policy stated that uninsured/underinsured coverage "is only in effect if your primary Uninsured and Underinsured

374. Id. at 875, 429 S.E.2d 291.
375. Id.
376. Id. at 876, 429 S.E.2d at 291.
378. Id. at 55, 438 S.E.2d at 168.
379. Id. at 56, 438 S.E.2d at 169.
380. Id.
381. Id. at 57, 438 S.E.2d at 169. It is interesting to note that laches, once a defense exclusive to equity (an unexplained delay in asserting one's rights resulting in prejudice to the defendant) has now seeped into administrative law and actions at law as is shown by many insurance cases.
Motorist limits are shown in the Section III Schedule. The claimant did have a $50,000 primary uninsured/underinsured coverage under another policy, but the Section III Schedule in the excess policy indicated "No Coverage." The claimant contended "No Coverage" was "tantamount to a specification of a coverage limit of $0, thereby giving rise to underinsured coverage of $1,000,000," the limit of the umbrella policy. The claimant also contended that she had a claim under the "Other Insurance" clause in the umbrella policy, which provided that "[o]ur coverage is excess over any other insurance. This means all insurance which covers you . . . whether it is shown in the Section III Schedule or not." The court of appeals dismissed this fallacy. There was no ambiguity. "No Coverage" meant precisely what it said; uninsured/underinsured coverage would be provided only if primary limits were in fact indicated in the Section III Schedule. Thus, the umbrella provided no such coverage. The general "Other Insurance" clause "created no independent right to insurance," but merely asseverated any coverage furnished by the umbrella policy under whatever rubric was agreed to be excess only. Since the "No Coverage" clause was the more specific provision, it would prevail over the more general "Other Insurance" clause even if one were to concede there was a conflict between the two.

383. Id. at 479, 436 S.E.2d at 516 (quoting the policy).
384. Id. at 480, 436 S.E.2d at 516.
385. Id., 436 S.E.2d at 517 (quoting the policy) (emphasis added).
386. Id., 436 S.E.2d at 516.
387. Id.
388. Id.
389. Id., 436 S.E.2d at 516-17.
390. Id., 436 S.E.2d at 517.
391. Id.
392. Id.