



1990

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R. Brent Cooper

Huddleston W. Huddleston

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Recommended Citation

R. Brent Cooper, et al., *Insurance Law*, 44 Sw L.J. 329 (1990)
<https://scholar.smu.edu/smulr/vol44/iss1/13>

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INSURANCE LAW

by

R. Brent Cooper*
and Michael W. Huddleston**

I. EXCESS LIABILITY

A. Refusal to Defend

LIMITATIONS. In *Woods v. William M. Mercer, Inc.*¹ the supreme court addressed the issue of whether the plaintiff or the defendant had the burden of proof in establishing limitations once the discovery rule was raised. On February 8, 1978, Peggy Woods, a registered nurse anesthetist, administered anesthesia to Mrs. Bassham during childbirth. Mrs. Bassham died from complications related to the anesthesia on February 24, 1978. At the time, Woods was covered by an insurance policy issued by Glacier General Insurance Company. The agent procuring the policy was William M. Mercer, Inc. The policy issued by Glacier was a claims-made policy covering claims that arose and were reported during the policy period. Subsequent to the death of Mrs. Bassham, Woods changed her insurance to an "occurrence" policy. This type of policy covered claims arising from an event that occurred during the policy period regardless of when the actual claim was reported to the carrier. Because of the transition from a "claims-made" policy to an "occurrence" policy, a potential gap in coverage was created.² To bridge this gap, Mercer gave Woods the opportunity to purchase "tail coverage," which extended the period for reporting under the "claims-made" policy.³ Woods had until June 20, 1988, to purchase the tail coverage. Mercer received the check on June 21. Since the payment was one day late, Mercer informed Woods that it could not comply with her request for coverage. Mercer did not forward the application for tail cover-

* B.B.A., Texas A & M University; J.D., Southern Methodist University. Attorney at Law, Cowles & Thompson, Dallas, Texas.

** B.B.A., Texas A & M University; J.D., Southern Methodist University. Attorney at Law, Cowles & Thompson, Dallas, Texas.

The authors gratefully acknowledge the assistance of Teresa G. Bohne, Mickie S. Fleetwood, Charles T. Frazier, J. Stephen Gibson, R. Michael Northrup, Judith H. Winston, and Stella Grace Youngblood, Attorneys at Law, members of the Appellate and Insurance Section of Cowles & Thompson, in the preparation of this Article.

1. 769 S.W.2d 515 (Tex. 1988). *Woods* was decided in December 1988, too late for discussion in last year's Survey of insurance law.

2. For example, a wrongful act occurring during the policy period of the claims-made policy, which was not reported until the policy period for the later "occurrence" policy, would not be covered under either policy.

3. This type of coverage should extend the period under the claims-made policy for invoking coverage by reporting the claims.

age to Glacier. At trial, Woods argued that Mercer's representation that the application for tail coverage was untimely was false and that had Mercer forwarded the application, she would have had coverage.

On October 22, 1978, counsel for the Bassham family gave notice of their intent to file suit for the death of Mrs. Bassham. Mercer and Glacier refused to defend Woods. The Basshams received judgment against Woods in the amount of \$1,209,016.59, plus post-judgment interest. The judgment became final on May 14, 1981. In April 1983 Woods brought suit against Glacier and Mercer for damages she sustained as a result of their failure to provide coverage and a defense. At trial, no questions pertaining to the statute of limitations defense were presented to the jury. The jury found for Woods on her DTPA and other claims, and judgment was entered against Mercer and Glacier for three times the amount of the prior judgment, plus interest.

The court of appeals ruled that Woods' action was barred by the statute of limitations because the evidence conclusively established that Woods knew more than two years prior to the filing of her lawsuit of the facts concerning the alleged misrepresentation.⁴ The supreme court affirmed the court of appeals' ruling as to Mercer on the basis of the statute of limitations.⁵ The court noted that confusion had arisen surrounding the discovery rule and took the opportunity to clarify the rules of pleading and proof governing the assertion of that discovery rule in a trial on the merits.⁶ The court initially ruled that the statute of limitations is an affirmative defense that must be pleaded and proved by the defendant.⁷ Once the defendant establishes the limitations defense, the plaintiff may raise the discovery rule as an excuse for its failure to file within the appropriate period of limitations.⁸ The court ruled that the discovery rule is an excuse for the plaintiff's failure to file within the appropriate period of limitations and thus it is a plea of confession and avoidance.⁹

Following *Smith v. Knight*¹⁰ the court held that a plaintiff seeking to avail

4. *William M. Mercer, Inc. v. Woods*, 717 S.W.2d 391, 397 (Tex. App.—Texarkana 1986).

5. 769 S.W.2d at 517. Prior to *Woods*, some question had existed in the case law as to the date a cause of action against an insurer accrued when there was a denial of a defense that resulted in an adverse judgment. Rather than bifurcating the causes of action as the court did in *Nash v. Carolina Casualty Ins. Co.*, 741 S.W.2d 598, 600-01 (Tex. App.—Dallas 1987, writ denied) (cause of action for denial of defense ran from date of denial and cause of action for failure to settle ran from date judgment became final), the *Woods* court treated all causes as accruing at the time of the earliest cognizable injury, which in that case was the date of the denial of the defense. 769 S.W.2d at 518. This result is consistent with prior guidelines given by the court in *Atkins v. Crosland*, 417 S.W.2d 150, 153 (Tex. 1967). The court also recognized that the insured suffered injury sufficient to start the running of the statute of limitations even though a courtesy defense was provided to her by the insurers for the other defendants. *Woods*, 769 S.W.2d at 518.

6. 769 S.W.2d at 516-18. See *infra* discussion at note 13 regarding the different treatment of the rule in a summary judgment setting.

7. *Id.* at 517.

8. *Id.*

9. *Id.*

10. 608 S.W.2d 165, 166 (Tex. 1980).

itself of the discovery rule must plead it in response to the defendant's assertion of limitations.¹¹ The court added that the party seeking the benefit of the discovery rule must also present evidence to the trier of fact and secure favorable findings from the trier of fact with respect to that rule.¹² The court found that Woods had neither pleaded nor obtained findings on the discovery rule and as a result waived her right to rely upon it as a means of avoiding the statute of limitations.¹³

B. *Stowers Liability*

Duty to Settle Limited by Limits of Liability. In *Pullin v. Southern Farm Bureau Casualty Insurance Co.*¹⁴ Southern Farm issued an automobile liability policy to Pullin. The policy contained limits of \$100,000 per person and \$300,000 per occurrence. On July 20, 1980, Pullin was involved in an automobile accident that injured seven persons. Two of the personal injury claims were settled for \$34,000. The remaining five claims belonged to members of the Schlueter family. The most severe claim belonged to Lennard Schlueter, whom the accident rendered a quadriplegic with brain damage. The Schlueters' first offer of settlement called for payment of the remaining \$266,000 under the policy limits. This settlement offer was broken down into \$100,000 for Lennard, plus amounts ranging from \$6,500 to \$90,000 for the other family members. Southern Farm counteroffered the \$100,000 policy limits for Lennard's claim and reduced amounts for the other family members. Eventually, the other family members' claims were settled for an aggregate of \$125,000. Lennard's claim went to trial, resulting in a judgment of \$950,000. Following the judgment, Southern Farm Bureau paid its \$100,000 policy limit.

The Pullins filed suit against Southern Farm following the judgment. The Pullins contended that the insurance company should have settled for the inflated values of the claims of the four other Schlueter family members in order to make more money available to cover Lennard's claim and in order to avoid any excess judgment. The Pullins argued that the existence of per person bodily limits should not be a defense to an insurance company's offer to settle for less than the per occurrence limit of liability if the tender of the

11. 769 S.W.2d at 518.

12. *Id.*

13. *Id.* at 518 n.2. The court noted that the burden does not apply in summary judgment cases. *Id.* (citing *Weaver v. Witt*, 561 S.W.2d 792, 794 (Tex. 1977)). The authority relied on by the court, by its own admission, had erroneously treated the discovery rule as part of the burden of proof of when the cause of action accrued, making the discovery rule a part of the defendant's burden of proof. *Id.* at 517. If the rule is a matter of confession and avoidance, in other words an affirmative defense to an affirmative defense, it should be treated no differently from any other such defense on summary judgment, which would require the nonmovant to prove the pleading in avoidance. See, e.g., *McClellan v. Boehmer*, 700 S.W.2d 687, 691 (Tex. App.—Corpus Christi 1985, no writ). The court has made the discovery rule a hybrid defense that must be awkwardly applied from a procedural standpoint. 769 S.W.2d at 519. At the very least, even under *Woods*, the defendant should not have to defeat the discovery rule if it has not been pleaded by the plaintiff. *Id.* at 518. Pleading burdens do not change under summary judgment practice; only evidentiary burdens are changed. *Id.*

14. 874 F.2d 1055 (5th Cir. 1989).

per occurrence limits would relieve any particular insured from exposure to a judgment in excess of the policy limits.

The Fifth Circuit Court of Appeals affirmed the trial court's summary judgment, holding that the *Stowers* doctrine does not require an insurance company to artificially inflate some claims so that its per person limit can in effect be exceeded on a more serious bodily injury claim.¹⁵ The court specifically noted that the cases cited by the Pullins in no way supported the proposition that an insurer has a duty to effect a settlement beyond its policy limits.¹⁶ The court recognized¹⁷ that the Pullins' argument had been specifically rejected by the Texas courts in *Rosell v. Farmers Texas County Mutual Insurance Co.*¹⁸ The court concluded that the duty sought by appellants was nothing more than an attempt "at generosity with the insurance company's money," which would require ignoring the specific terms of the liability policy.¹⁹

C. Good Faith and Fair Dealing

Reasonable Basis for Denial of Claim. In 1988 Texas courts provided significant clarification of the newly developed duty of good faith and fair dealing. In particular, the courts began to explain that there are some situations in which an insurer, as a matter of law, has a reasonable basis for denial of or delay in payment of a claim and thus will not be guilty of any breach of the duty of good faith and fair dealing. The first case to address this issue was *Fuentes v. Texas Employers Insurance Association*.²⁰ In that case the San Antonio court of appeals held that a worker's compensation insurer that denied a claim based upon a medical opinion had, as a matter of law, a reasonable basis for denying the claim and could not be guilty of breach of

15. *Id.* at 1056.

16. *Id.* at 1057. The Pullins cited: *Employer's Nat'l Ins. Co. v. Zurich American Ins. Co.*, 792 F.2d 517, 519 (5th Cir. 1986); *Texoma Ag-Products v. Hartford Accident & Indem. Co.*, 755 F.2d 445 (5th Cir. 1985); *Ranger County Mutual Ins. Co. v. Guin*, 723 S.W.2d 656 (Tex. 1987).

17. 874 F.2d at 1056.

18. 642 S.W.2d 278 (Tex. App.—Texarkana 1982, no writ). *Rosell* arose out of an accident in which a vehicle driven by Don Wood struck the Rosells' daughter. Wood was insured under an automobile policy with limits of \$10,000 per person and \$20,000 per occurrence. Farmers offered to settle for \$10,000 on the daughter's cause of action and \$5,000 on Rosell's cause of action for emotional distress. Rosell declined, demanding \$10,000 for each claim. Farmers refused to settle and the case was tried to a jury. Judgment was rendered in favor of the daughter for \$55,000 and in favor of Rosell for \$5,625. Suit was then brought against Farmers under the *Stowers* doctrine for the excess judgment obtained by the daughter. Summary judgment was granted by the trial court. The Texarkana court of appeals affirmed, holding that Farmers should not be required to offer the total \$20,000 per occurrence limit of liability in order to pay in excess of \$10,000 for the single claim of the daughter. *Id.* at 280. The court rejected this "trust fund" theory and held that the per person limit controls the maximum settlement an insurance company is required to offer each claimant. *Id.* As a result, the court held that Farmers had not committed unconscionable action, failed to negotiate settlement in good faith, or breached any of the duty of good faith and fair dealing. *Id.*

19. 874 F.2d at 1057.

20. 757 S.W.2d 31 (Tex. App.—San Antonio 1988, no writ), *discussed in* Cooper & Huddleston, *Insurance Law, Annual Survey of Texas Law*, 43 Sw. L.J. 343, 353 (1989).

the duty of good faith and fair dealing.²¹

During the 1989 Survey period the courts of appeals handed down three additional decisions. These decisions are critical in providing guidance to attorneys and insurance carriers as to the manner in which claims are to be handled. In *National Union Fire Insurance Co. v. Hudson Energy Co.*²² the owner of an aircraft brought suit for property damage to the aircraft sustained when it flipped during landing. Prior to the time of the accident, a student pilot was piloting the aircraft. Once the aircraft touched down on the runway, however, the instructor also assumed the controls. The policy required that a designated pilot be operating the aircraft in order for there to be coverage. National Union took the position that since the student pilot, who was not a designated pilot, was operating the aircraft, there was no coverage. The jury found that the aircraft was being operated by a pilot designated in the declarations and that National Union had breached its duty of good faith and fair dealing. On appeal, the Texarkana court of appeals reversed the finding of the jury as to the breach of the duty of good faith and fair dealing.²³ The court held that a delay or refusal to pay was not unreasonable in the face of a legitimate question of policy construction.²⁴ The court noted that the matter of simultaneous flight by an authorized pilot and an unauthorized pilot was a question of first impression in Texas and as a matter of law formed a reasonable basis for National Union's litigating the claim.²⁵ The court went on to hold that false statements given by the insured in the insurance application also formed a reasonable basis as a matter of law for National Union to refuse to pay the claim.²⁶

21. 757 S.W.2d at 33. The development of this area of law is consistent with the positions taken by other jurisdictions that have adopted the duty of good faith and fair dealing. These jurisdictions have determined the following acts to constitute a reasonable basis as a matter of law for a denial of a claim: (1) reliance upon medical opinion of a treating physician, *Nichols v. North Am. Equitable Life Assur. Co.*, 502 So. 2d 375, 377-78 (Ala. 1987); (2) reliance upon statements in hospital records, *National Sav. Life Ins. Co. v. Dalton*, 419 So. 2d 1357, 1361-62 (Ala. 1982); (3) reliance upon veterinarian records, *Lasma Corp. v. Monarch Ins. Co.*, 159 Ariz. 59, 764 P.2d 1118, 1122-23 (1988); (4) refusal of insured to cooperate in investigation or give a statement, *Cherry v. Anthony, Gibbs, Sage*, 501 So. 2d 416, 420 (Miss. 1987); (5) contradictory statements given by insured as to how loss occurred, *Amco Ins. Co. v. Stammer*, 411 N.W.2d 709, 712-13 (Iowa Ct. App. 1987); (6) reliance upon fire marshall's report, *Suggs v. State Farm Fire & Casualty Co.*, 833 F.2d 883, 891 (10th Cir. 1987); (7) existence of legal issues as to liability and coverage, *Taylor v. Commercial Union Ins. Co.*, 614 F.2d 160, 164-65 (8th Cir. 1980); (8) reliance upon attorney's advice, *Dill v. Claims Administration Serv's, Inc.*, 178 Cal. 3d 1184, 1190, 224 Cal.Rptr. 273, 276-77 (1986). Many jurisdictions have recognized the dangers of submitting every case of alleged bad faith to a jury. Every denial, even if wrongful, does not give rise to a cause of action for breach of duty of good faith and fair dealing. *Arnold v. National County Mut. Ins. Co.*, 225 S.W.2d 165 (Tex. 1987). To guard against the prejudices that may exist in the minds of some jurors, it is necessary for the courts to fashion "safe harbors" where an insurer may act reasonably and not be subjected to the whims of a jury.

22. 780 S.W.2d 417 (Tex. App.—Texarkana 1989, writ granted).

23. *Id.* at 424-27.

24. *Id.* at 424.

25. *Id.* at 426-27.

26. *Id.* at 426 (citing *Anderson v. Nationwide Life Ins. Co.*, 627 P.2d 344 (Kan. Ct. App. 1981)).

In *Progressive County Mutual Insurance Co. v. Boman*²⁷ the insured brought a claim against his insurer based on the insurer's failure to pay a claim for property damage to the insured's motorcycle. In his application for the insurance, the insured represented that the motorcycle would not be used for business, but would be used for pleasure only. While using the motorcycle in his occupation as a police officer, Boman was involved in a collision with a pickup truck that resulted in property damage to the motorcycle. The jury found that Progressive committed a breach of the duty of good faith and fair dealing when it refused to pay Boman for the damage to the motorcycle. The court of appeals held that the evidence was factually insufficient to establish a breach of the duty of good faith and fair dealing.²⁸ The court held that Progressive had persuasive coverage defenses on at least two bases and thus had a reasonable basis for denial: first, the policy was void because of misrepresentation on the application with regard to where the motorcycle would be stored; second, the motorcycle was being used for business purposes when Boman had represented that it would be used only for pleasure purposes.²⁹

In *Harco National Insurance Co. v. Villanueva*³⁰ the court held that an insurer's reliance upon the investigation report of an unlicensed investigator, which was riddled with inconsistencies, did not constitute a reasonable basis as a matter of law for denial of a claim.³¹ The court noted that the investigator claimed that three days after the theft of the automobile, he saw a "tall, slim Mexican male with a mustache" inside a truck similar in appearance to the one stolen from Villanueva.³² Villanueva was in fact a short, stocky, hispanic male who had never worn a mustache. In addition, Villanueva furnished the carrier with a sworn statement that he was in Houston visiting his accountant about his income tax returns on the day he was allegedly seen in the stolen truck. The insurance carrier failed to ask the insured for any corroborating evidence or take any investigative action to check the validity of the story.

Tort Claims Act. In *Murray v. San Jacinto Agency, Inc.*³³ a participant in an independent school district's self-funded group medical insurance program filed suit against the school district and the administrator of the plan after the administrator/insurer denied coverage. Subsequent to the denial, the school district and administrator/insurer admitted that a mistake had been made and reinstated coverage. Murray sued the school district, asserting that it was liable as the provider of a self-funded group medical insurance program for damages under the tort of the duty of good faith and fair dealing. The trial court granted summary judgment to the school district on the basis of governmental immunity. On appeal, the plaintiff contended that the

27. 780 S.W.2d 436 (Tex. App.—Texarkana 1989, no writ).

28. *Id.* at 438-39.

29. *Id.* at 439.

30. 765 S.W.2d 809 (Tex. App.—Dallas 1988, writ denied).

31. *Id.* at 811.

32. *Id.*

33. 759 S.W.2d 778 (Tex. App.—El Paso 1988, writ granted).

establishment of a self-funded insurance program was a proprietary as opposed to a governmental function. The El Paso court of appeals disagreed, holding that an independent school district, unlike a city or town, performs no proprietary functions that are separate and independent of its governmental powers.³⁴ The court held that a bad faith claim does not fall within any waiver of governmental immunity and affirmed the trial court's summary judgment in favor of the school district.³⁵

Severance. In *General Life & Accident Insurance Co. v. Handy*³⁶ the insurer denied coverage on the basis that the insured's physical condition was excluded from coverage because the condition manifested itself before thirty days after the effective date of the policy. The carrier also asserted that the pre-existing condition clause of the policy barred recovery. The insured alleged that the insurer breached the contract and the duty of good faith and fair dealing, as well as article 21.21 of the Texas Insurance Code.³⁷ A jury trial resulted in a verdict favorable to the insured. On appeal, the insurer contended that the trial court erred in failing to sever the breach of contract claim from the bad faith claim. The El Paso court of appeals disagreed with the carrier's position on the basis that footnote 1 of *Arnold v. National County Mutual Fire Insurance Co.*³⁸ specifically stated that its holding did not mean that a contract claim and a claim for breach of duty of good faith and fair dealing could not be tried together when possible.³⁹

Absent from the court of appeals' opinion are the circumstances, if any, the carrier presented in support of its motion to sever the two causes. Clearly, there are circumstances in which it would be erroneous to allow the bad faith claim to be tried with the claim for breach of contract. The scope of discovery as well as the scope of relevant evidence is significantly broader with a bad faith claim. Where the combination of the two claims would allow the discovery and introduction of evidence in connection with the claim for breach of contract, which would otherwise not be admissible, then the trial court should exercise its discretion in severing the two claims so as to avoid any prejudicial impact from the otherwise inadmissible evidence.

Acts of Agent. In *Paramount National Life Insurance Co. v. Williams*⁴⁰ an insured brought an action against her health insurance carrier for denial of a claim and cancellation of her policy. One of the bases for denial and cancellation was the insured's alleged failure to disclose her complete medical history. At trial the insurer contended that had the insured disclosed her entire medical history, it would not have issued the policy. The insured contended that she disclosed all her medical history to the agent, but that he told her that he only needed to know about the preceding five years. Paramount

34. *Id.* at 779 (citing *Braun v. Trustees of Victoria Indep. School Dist.*, 114 S.W.2d 947 (Tex. App.—San Antonio 1938, writ ref'd)).

35. *Id.* at 780.

36. 766 S.W.2d 370 (Tex. App.—El Paso 1989, no writ).

37. TEX. INS. CODE ANN. art. 21.21 (Vernon 1981).

38. 725 S.W.2d 165 (Tex. 1987).

39. 766 S.W.2d at 375.

40. 772 S.W.2d 255 (Tex. App.—Houston [14th Dist.] 1989, writ denied).

contended that while the agent acted for the carrier in delivering the policy and collecting the premiums, he was acting for the insured in making the application for the insurance and processing the policy. The agent apparently had a soliciting agent's license. The court noted that a soliciting agent's authority is more limited than that of a local recording agent.⁴¹ In this case, however, the court held that even though a soliciting agent may not bind an insurer by his misrepresentations, he may, under certain circumstances, make the insurer liable for extra-contractual damages.⁴² The court noted that absent actual authority, an agent may still have apparent authority to act for the carrier.⁴³ In this case, the agent used Paramount forms when he took the application from the insured, and the application referred to the relationship of the agent to Paramount as "your agent." Furthermore, the receipt for the initial premium was signed by the agent as the "duly licensed representative" of Paramount.⁴⁴ Based on the foregoing, the court held that apparent authority existed.⁴⁵ With respect to the bad faith claim, the court found that had Paramount investigated the claim more thoroughly, it would have found that the problem with the insured's application was due not to her failure to make a full disclosure but to its agent's failure to complete the application accurately and fully.⁴⁶

A similar situation was involved in *Wilkins v. Time Insurance Co.*⁴⁷ In that case an agent, Lester, sold a major medical and life insurance policy to the Dove Christian Retreat. Time Insurance Company issued the policy, which covered Dove's officers and employees. Aquilla Wilkins was an officer. Wilkins told Lester that she had a twenty-year history of fibrocystic disease, but Lester did not place the information on the enrollment form. Approximately a year after the policy had been in place, Time sent a letter to Wilkins advising her that because the policy had been in force for one year, the policy would cover pre-existing conditions. Thereafter, Wilkins had surgery for removal of breast masses. Time Insurance Company denied her resultant claim for medical expenses, alleging that Wilkins had failed to reveal her pre-existing fibrocystic condition.

The jury refused to find that Time had breached its duty of good faith and fair dealing. On appeal, Wilkins contended that the findings were against the great weight and preponderance of the evidence. The Texarkana court of appeals agreed.⁴⁸ The court noted that the trial court had determined that as a matter of law the policy was in effect and that Time had no right to rescind it.⁴⁹ Furthermore, the court found that Ms. Wilkins did in fact reveal her pre-existing condition.⁵⁰ Therefore, misrepresentation could not

41. *Id.* at 262.

42. *Id.* at 262-63.

43. *Id.* at 261.

44. *Id.*

45. *Id.*

46. *Id.* at 264.

47. 1990 WL 66792 (Tex. App.—Texarkana 1990).

48. *Id.* at 2.

49. *Id.* at 3.

50. *Id.*

constitute a reasonable basis for Time's denial of payment, and the record was devoid of any other explanation that would form a reasonable basis for denial or delay in payment.⁵¹

Res Judicata. The disposition in *Marino v. State Farm Fire & Casualty Insurance Co.*⁵² followed an earlier Marino suit against State Farm where Marino claimed State Farm had wrongfully denied his claim for losses due to fire. In that lawsuit, Marino made a claim not only in connection with the loss of the house, but also that State Farm was guilty of false, misleading, or deceptive acts or practices in its dealings with him. Marino asserted that State Farm acted unconscionably by taking advantage of his lack of knowledge, ability, experience, or capacity, all of which resulted in a gross disparity between the value he received and the consideration he paid. State Farm denied the claim, contending that Marino had set fire to his own house. At the trial, the jury failed to find that Marino had set fire to his house and found the amount of damage to the house and contents. No issues were submitted to the jury inquiring about State Farm's dealings with Marino and the handling of the loss. The court entered judgment in favor of Marino for the amount of the loss plus attorneys' fees, but it made no award for the handling of the claim.

Thereafter, Marino filed suit against State Farm, alleging that State Farm breached its duty of good faith and fair dealing in regard to his claim. The trial court granted summary judgment in favor of State Farm on the basis that the claim was barred by the doctrine of res judicata. The Fort Worth court of appeals held that the doctrine of res judicata barred litigation of all issues that might have been tried in the former trial.⁵³ The court held that the cause of action for the duty of good faith and fair dealing grew out of the same operative facts as the claims asserted by Marino in the first suit concerning violations of the Texas Insurance Code and Deceptive Trade Practices Act and could have been litigated in the first suit.⁵⁴

Marino asserted that under *Arnold v. National County Mutual Fire Insurance Co.*⁵⁵ the statute of limitations for the breach of the duty of good faith and fair dealing does not begin to run until after the underlying insurance contract claims are finally resolved. The court of appeals noted that an insured is permitted to litigate his good faith claim and contract claim separately only when the claims arise from distinct subject matters.⁵⁶ The court added, however, that if the insured elects to join his claim for improper handling of the claim with his contract claim, it will later operate as res judicata insofar as the breach of the duty of good faith and fair dealing since the breach of that duty arises out of the same operative facts as a claim for improper handling of the claim.⁵⁷

51. *Id.*

52. 774 S.W.2d 107 (Tex. App.—Fort Worth 1989, writ granted).

53. *Id.* at 109.

54. *Id.*

55. 725 S.W.2d 165, 168 (Tex. 1987).

56. 774 S.W.2d at 109.

57. *Id.*

Punitive Damages. In *National Union Fire Insurance Co. v. Valero Energy Corp.*⁵⁸ Valero sued National Union, its builder's risk insurer, for failing to provide coverage for property damage incurred during refinery construction. The case was tried to a jury, which found a covered loss in the amount of \$10,000,000. The jury found that the denial of the claim was without a reasonable basis and also awarded exemplary damages in the amount of \$15,000,000. On appeal, National Union contended, among other things, that there was no basis in the verdict to support the award of exemplary damages. The jury had found only that National Union had acted unreasonably in the denial of the claim. No issue had been submitted inquiring whether the conduct of the insurer was intentional.

National Union objected to the submission of the issue of exemplary damages. The insurer argued that the trial court's failure to submit an issue regarding gross negligence or willful, malicious acts prevented an exemplary damage award. The Corpus Christi court of appeals agreed, holding that the mere finding of a breach of the duty of good faith and fair dealing would not by itself support an award of exemplary damages.⁵⁹ The court observed⁶⁰ that any other approach would be contrary to the supreme court's holding in *Arnold v. National County Mutual Fire Insurance Co.*⁶¹ and *Chitsey v. National Lloyd's Insurance Co.*⁶² The court noted that the reasonableness standard established by the duty of good faith and fair dealing has been likened to the ordinary prudent person standard of a general negligence case.⁶³ While exemplary damages may be recovered for the breach of duty of good faith and fair dealing, the supreme court cases cited by the *Valero* court show that exemplary damages may be recovered only when an insurer has acted willfully, maliciously, or with conscious indifference.⁶⁴

Preemption. In *Gibbs v. Service Lloyds Insurance Co.*⁶⁵ the plaintiff sued his employers' workers' compensation carrier for breach of the duty of good faith and fair dealing in handling his claim. Service Lloyds was able to remove the case from the state court on the grounds that ERISA preempted Gibbs' cause of action.⁶⁶ Gibbs filed a motion to remand, arguing that workers' compensation insurance was exempt from ERISA by 29 U.S.C. § 1003(b)(3).⁶⁷

The employer in this case had purchased two policies that provided insurance benefits to his employees. The Service Lloyds policy provided workers' compensation insurance as well as insurance that protected the employer

58. 777 S.W.2d 501 (Tex. App.—Corpus Christi 1989, no writ).

59. *Id.* at 511.

60. *Id.*

61. 725 S.W.2d 165 (Tex. 1987).

62. 738 S.W.2d 641 (Tex. 1987).

63. 777 S.W.2d at 511.

64. *Id.*

65. 711 F. Supp. 874 (E.D. Tex. 1989).

66. 29 U.S.C. §§ 1001-1461 (1988); see *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

67. This section provides that "the provisions of this subchapter shall not apply to any employee benefit if . . . such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws . . ." 29 U.S.C. § 1003(b)(3) (1988).

from punitive damages under common or statutory law. The second insurance policy, from Businessmen's Assurance Company of America, provided health insurance benefits, but specifically excluded any coverage for workers' compensation insurance. Following *Shaw v. Delta Airlines, Inc.*⁶⁸ the court noted the exemption applied only to "separately administered" plans provided "solely to comply" with applicable state law.⁶⁹ Service Lloyds argued that the workers' compensation program was not a separately administered plan because it was part of an overall plan that included health insurance for the employees. Service Lloyds contended that the employer had one overall employee benefit plan and administered that plan as a single unit. The court disagreed and found that the plan was a "separately administered" benefit for several reasons. First, the court noted that there were two different policies providing distinct types of insurance from two different insurers.⁷⁰ Second, the court noted that only in a limited sense did the employer act as an administrator; the authority to approve any claim rested with the respective insurance carrier.⁷¹ The court concluded that a review of the administrative structure of the workers' compensation and multi-benefit insurance programs led to the inevitable conclusion that the programs were separately administered by the respective carriers.⁷² The court further found that the employers' workers' compensation plan was provided solely to comply with the applicable state law.⁷³ The court noted that in Texas the workers' compensation scheme is not mandatory but elective.⁷⁴ In order to enjoy the benefits and immunities provided to subscribers, the workers' compensation plan must comply with the applicable law.⁷⁵ Service Lloyds argued that since the policy also provided coverage for punitive damages, it was not issued solely to comply with Texas workers' compensation laws. The court noted that while this type of insurance is not required by Texas law, its existence does not interfere with any of the federal ERISA interests.⁷⁶ By purchasing another form of insurance as part of the workers' compensation policy, the employer does not take the workers' compensation plan out of the section 1003(b)(3) exemption.⁷⁷

Retroactive Effect. In *Service Lloyds Insurance Co. v. Greenhalgh*⁷⁸ an employee brought an action against his workers' compensation carrier for bad faith, unfair insurance practices, negligence, gross negligence, and intentional infliction of emotional distress on the basis of a claim denied. The jury

68. 463 U.S. 85, 107-08 (1983).

69. 711 F. Supp. at 878.

70. *Id.* at 877.

71. *Id.*

72. *Id.*

73. *Id.* at 878.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. 771 S.W.2d 688 (Tex. App.—Austin 1989), *rev'd*, *Greenhalgh v. Service Lloyds Ins. Co.*, 33 Tex. Sup. Ct. J. 387 (April 11, 1990). The supreme court reversed only as to the propriety of the trial amendment to increase the amount claimed for punitive damages. 33 Tex. Sup. Ct. J. at 388-89.

found in favor of the employee on all five theories. While the case was on appeal, the Texas Supreme Court decided *Aranda v. Insurance Co. of North America*,⁷⁹ which extended the common law duty of good faith and fair dealing to workers' compensation carriers. At issue in *Greenhalgh* was whether *Aranda* was to be applied retroactively to cases that were not yet final. The court reasoned that while generally decisions of the supreme court do apply retroactively, considerations of fairness and public policy can serve to prevent retroactive effect.⁸⁰ The court stated that the carrier could not have relied to its detriment upon any prior rule of law because, prior to *Aranda*, the supreme court had never addressed the issue of the duty of good faith and fair dealing in the workers' compensation context.⁸¹ Thus, the court concluded that public policy and fairness considerations did not favor the carrier in this case and that *Aranda* was to be applied retroactively.⁸²

D. Deceptive Trade Practices Act and Article 21.21 of the Insurance Code Frequency Requirement. On two occasions courts of appeals took the opportunity to reaffirm the principle that a private cause of action existed against an insurance company for engaging in unfair claims settlement practices under the Deceptive Trade Practices Act regardless of whether such activities occurred with sufficient frequency as to indicate a general business practice. In *Stewart Title Guaranty Co. v. Sterling*⁸³ an insured brought suit against its title insurer for defects in the title of which the insured claimed the title insurer had actual knowledge. On appeal, Stewart Title contended that no private cause of action existed unless the evidence showed that the type of conduct in question occurred with such frequency as to indicate a general business practice. The court of appeals correctly rejected this argument,⁸⁴ but it did so for the wrong reason. The court held that under *Vail v. Farm Bureau Mutual Insurance Co.*⁸⁵ proof of frequency was not a requisite element to prove a cause of action based on any of the acts or practices defined in article 21.21-2 and section 16 of article 21.21 of the Texas Insurance Code.⁸⁶ A close examination of *Vail* reveals that the cause of action in that case was not under article 21.21 of the Insurance Code but rather was brought pursuant to the provisions of the DTPA.⁸⁷

79. 748 S.W.2d 210 (Tex. 1988).

80. 771 S.W.2d at 691 (citing *Linkletter v. Walker*, 381 U.S. 618, 626-29 (1965); *Sanchez v. Schindler*, 651 S.W.2d 249, 254 (Tex. 1983)).

81. *Id.* at 691.

82. *Id.* at 691-92.

83. 772 S.W.2d 242 (Tex. App.—Houston [14th Dist.] 1989, writ granted).

84. *Id.* at 244.

85. 754 S.W.2d 129 (Tex. 1988).

86. 772 S.W.2d at 244; see Tex. Ins. Code Ann. art. 22.21, § 16, art. 21.21-2 (Vernon 1981).

87. The court in *Vail* held that the plaintiffs proved a cause of action for bad faith claims handling practices under § 17.50(a)(4) of the DTPA on three alternative grounds. TEX. CIV. PRAC. & REM. CODE ANN. § 17.50(a)(4) (Vernon 1986). First, the court found the Vails had proved a cause of action under § 17.46(b) of the DTPA by obtaining a finding that the insurer had failed to exercise good faith. 754 S.W.2d at 135; TEX. CIV. PRAC. & REM. CODE ANN. § 17.46(b) (Vernon 1986). The court held that this finding fell within the broad ambit of

The second court to address the frequency requirement was the Dallas court of appeals in *Aetna Casualty & Surety Co. v. Joseph*.⁸⁸ In this case Joseph brought suit against his homeowner's insurance carrier for damages resulting from the theft of silverware from his home. Joseph sued Aetna for a breach of its contract to pay him benefits for stolen property and for bad faith in its delay in settling the claim. The jury found for Joseph, awarding him \$21,677 for the cost of the silverware, \$5,000 for mental anguish, \$60,000 in exemplary damages, and \$18,000 for attorneys' fees in the trial court and on appeal. On appeal, Aetna contended that the jury answers would not support a judgment in that there was no finding that the company committed the acts complained of with such frequency as to indicate a general business practice. The court correctly recognized that under the DTPA, an insurer's failure to settle a claim in good faith is actionable without a showing that the acts were committed with such frequency as to indicate a general business practice.⁸⁹

Bad Faith Counterclaim. In *Blizzard v. Nationwide Mutual Fire Insurance Co.*⁹⁰ an insured brought an action against an insurer to recover under the uninsured motorist and personal injury protection provisions of a personal automobile policy. The insured also sued under the DTPA⁹¹ and article 21.21 of the Insurance Code.⁹² The insurer counterclaimed, alleging that the DTPA claims were groundless and brought in bad faith or for the purpose of harassment. The jury found that the insured had sustained damages in an amount less than that previously paid to her. In addition, the jury found that the insured's DTPA claim was brought in bad faith and for the purposes of harassment. The trial court rendered judgment denying *Blizzard* and *Nationwide* any relief.⁹³ The appeals court noted that a line of authority had developed among the courts of appeals following *O'Shea v.*

§ 17.46(b), which deals with "false and misleading or deceptive acts or practices." 754 S.W.2d at 135-36.

Second, the court incorporated into § 17.50(a)(4) of the DTPA [a] "Article 21.21, [b] section 16 of the Insurance Code, [c] Section 4(a) of Board Order 18663, and [d] the definition of unfair claims settlement practice in Article 21.21-1, Section 2(d) of the Insurance Code." *Id.* at 136. The majority in *Vail* made a logically suspect attempt to distinguish § 2 of art. 21.21-2 from Board Order 41454 by holding that frequency was not a prerequisite to the acts defined in art. 21.21-2 as unfair trade practices but rather was only a prerequisite to the issuance of cease and desist orders by the board. *Id.* at 135. This reasoning was an attempt to avoid the court's earlier holding in *Chitsey v. National Lloyds Ins. Co.*, 738 S.W.2d 641, 643 (Tex 1987), which imposed a requirement of frequency.

Finally, the court in *Vail* held that the plaintiff had stated a cause of action for unfair claim settlement practices by incorporating art. 21.21, § 16 of the Insurance Code, § (4)(b) of Board Order 18662, and the judicial determinations made by the court in *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987), and *Aranda v. Ins. Co. of North America*, 748 S.W.2d 210, 212-13 (Tex. 1988), into § 17.50(a)(4) of the DTPA.

88. 769 S.W.2d 603 (Tex. App.—Dallas 1989, no writ).

89. *Id.* at 607.

90. 756 S.W.2d 801 (Tex. App.—Dallas 1988, no writ).

91. TEX. CIV. PRAC. & REM. CODE ANN. § 17.50(c) (Vernon 1988).

92. TEX. INS. CODE ANN. art. 21.21 (Vernon 1981).

93. The Dallas court of appeals was presented with the question of whether the issues of bad faith and harassment were for the jury or for the court. The court in *Blizzard* was construing § 17.50(c) of the DTPA, which provides: "When a finding by the court that an action under this section was groundless and brought in bad faith, or brought for purposes of harass-

International Business Machines Corp.,⁹⁴ that the fact finding of groundlessness was a question of law for the court, but that the findings of bad faith or harassment were fact issues for the jury to decide.⁹⁵ The court refused to follow these holdings, noting that the supreme court in *Leissner v. Schott*⁹⁶ specifically reserved ruling on whether the bad faith/harassment issue presented a question of fact.⁹⁷ In *Schott* the court noted that the validity of the interpretation was not before it and accordingly reserved the judgment.⁹⁸

The Dallas court declined to follow the *O'Shea* line of cases and based its holding upon the first six words of section 17.50(c): "on a finding by the court."⁹⁹ The court noted that trial judges are at least as competent, if not more competent, than juries to determine the motivation of parties in litigation and that the determination by a trial court under these circumstances would be substantially similar to its responsibility under rule 13 of the Texas Rules of Civil Procedure.¹⁰⁰

Standing. In *Hermann Hospital v. National Standard Insurance Co.*¹⁰¹ Hermann Hospital brought suit against National Standard alleging violations of the DTPA and article 21.21 of the Texas Insurance Code. A fellow employee stabbed Carreon while both were working for their employer. National Standard was the workers' compensation carrier for Carreon's employer. National Standard paid for three months of treatment of Carreon at another hospital immediately following the injury. Prior to accepting Carreon as a transfer patient, Hermann Hospital verified insurance coverage with National Standard. After Carreon transferred to Hermann Hospital, National Standard denied coverage for the injuries sustained by the patient and refused to pay Hermann Hospital for the expenses incurred. The hospital asserted that it had relied upon the representation of coverage and had incurred expenses in the amount of \$217,444.90 in its treatment of Carreon.

National Standard moved for summary judgment on the basis that Hermann Hospital did not have standing under the DTPA or article 21.21 of the Texas Insurance Code. The trial court entered summary judgment in favor of National Standard. The court of appeals noted that Hermann Hospital's second amended petition did not allege an action under the DTPA and therefore the only issue regarding standing was whether the hospital had standing under article 21.21 of the Texas Insurance Code.¹⁰² The court of

ment, the court shall award to the Defendant reasonable and necessary attorneys fees and court costs." TEX. CIV. PRAC. & REM. CODE ANN. § 17.50(c) (Vernon 1986).

94. 578 S.W.2d 844 (Tex. Civ. App.—Houston [1st Dist.] 1979, writ ref'd n.r.e.).

95. Cases following this holding include: *Genico Distributors, Inc. v. First Nat'l Bank*, 616 S.W.2d 48 (Tex. Civ. App.—Texarkana 1981, writ ref'd n.r.e.); *Computer Business Serv., Inc. v. West*, 627 S.W.2d 759 (Tex. App.—Tyler 1981, writ ref'd n.r.e.); *Wickersham Ford, Inc. v. Orange County*, 701 S.W.2d 344 (Tex. App.—Beaumont 1985, no writ); *Shenandoah Assoc. v. J. & K. Properties, Inc.*, 741 S.W.2d 476 (Tex. App.—Dallas 1987, writ denied).

96. 668 S.W.2d 686 (Tex. 1984).

97. 756 S.W.2d at 809.

98. 668 S.W.2d at 687.

99. 756 S.W.2d at 810.

100. *Id.*

101. 776 S.W.2d 249 (Tex. App.—Houston [1st Dist.] 1989, writ denied).

102. *Id.* at 251.

appeals held that Hermann Hospital did have standing under article 21.21.¹⁰³ The court reasoned that section 16(a) of the Code provides a cause of action to “any person who has been injured by another’s engaging”¹⁰⁴ in acts declared unlawful by article 21.21.¹⁰⁵ The term “person” is defined by article 21.21 to mean: “any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance including agents, brokers, adjusters and life insurance counselors.”¹⁰⁶ The court went on to note that despite the clear language of the definition of “person,” the supreme court has interpreted the statute as not requiring that the injured party be a person who is engaged in the business of insurance.¹⁰⁷ Furthermore, article 21.21 does not require that the injured party be a consumer of goods or services before he can recover under the provisions of section 16.¹⁰⁸ The court was careful to point out that the decision was not to be construed as allowing an injured person to bring suit against the tortfeasors’ insurance carrier arising out of the handling of the claim.¹⁰⁹

II. LIABILITY INSURANCE

Equitable Relief—Duty to Defend. A Texas court of appeals has now ad-

103. *Id.* at 252.

104. TEX. INS. CODE ANN. art. 21.21 § 16 (Vernon 1981).

105. 776 S.W.2d at 252.

106. TEX. INS. CODE ANN. art. 21.21 § 2 (Vernon 1981).

107. 776 S.W.2d at 251; *see Ceshker v. Bankers’ Commercial Life Ins. Co.*, 568 S.W.2d 128, 129 (Tex. 1978).

108. 776 S.W.2d at 251; *see Aetna Casualty & Surety Co. v. Marshall*, 724 S.W.2d 770, 772 (Tex. 1987).

109. 776 S.W.2d at 251. The holding in *Hermann Hospital* on its face appears to be a very narrow one limited to situations where the carrier has made representations concerning coverage and there has been reliance by the plaintiff. The Houston (14th District) court of appeals had previously addressed this issue in the context of the duty of good faith and fair dealing in *Chaffin v. Transamerica Ins. Co.*, 731 S.W.2d 728 (Tex. App.—Houston [14th Dist.] 1987, writ ref’d n.r.e.). The court, however, held that the duty of good faith and fair dealing does not run between a liability carrier and a third-party claimant. *Id.* at 732. The majority rule in other jurisdictions is that the duty of good faith runs only to the insured, not to a third-party claimant. *See Dickey v. Alabama Farm Bureau Mut. Ins. Co.*, 447 So. 2d 693, 694 (Ala. 1984) (attempting to recover from automobile insurer for repairs to auto damaged in collision with the insured vehicle); *Murphy v. Allstate Ins. Co.*, 17 Cal. 3d 937, 940, 553 P.2d 584, 586, 132 Cal. Rptr. 424, 426 (1976) (seeking balance of wrongful death judgment from insurer of tortfeasor); *Ichler v. Scott Pools, Inc.*, 513 N.E.2d 665, 667 (Ind. Ct. App. 1987) (seeking damages from automobile accident in which plaintiff’s parents were insureds); *Linscott v. State Farm Mut. Auto. Ins. Co.*, 368 A.2d 1161, 1163 (Me. 1977) (charging deceit and misrepresentation by tortfeasor’s insurer); *Magalski v. Maryland Cas. Co.*, 21 Md. App. 136, 143, 318 A.2d 843, 849 (1974) (claiming damages for tortfeasor’s insurer’s refusal to pay property damage); *Chavez v. Chenoweth*, 89 N.M. 423, 553 P.2d 703, 709 (Ct. App. 1976) (claiming against defendant’s insurer for unreasonable delay); *D. H. Overmyer Telecasting Co. v. American Home Assurance Co.*, 29 Ohio App. 3d 31, 36, 502 N.E.2d 694, 698 (1986) (claiming against attorney’s liability insurer); *Tank v. State Farm Fire & Cas. Co.*, 105 Wash. 2d 381, 715 P.2d 1133, 1139 (1986) (claiming against insurer of defendant in assault action). Texas law would also dictate this result because the duty of good faith arises out of the special relationship that exists between the insurer and the insured. *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). This special relationship does not exist between the insured and the third-party claimant. *Duncan v. Lumbermen’s Mut. Cas. Co.*, 91 N.H. 349, 23 A.2d 325, 326 (1941).

dressed the important issue of whether injunctive relief invokes a duty to defend under a comprehensive general liability insurance policy. The court in *Feed Store, Inc. v. Reliance Insurance Co.*¹¹⁰ held that the insuring agreement of the "personal injury and advertising injury" coverage part required that the suit brought against the insured involve a claim for "damages" and not one for mere equitable relief.¹¹¹ The court began its analysis by noting that Texas courts follow the "complaint allegation" rule in determining the duty to defend.¹¹² The court curtly held that the evidence of financial expenditures involved extrinsic facts not alleged in the underlying complaint

110. 774 S.W.2d 73 (Tex. App.—Houston [14th Dist.] 1989, writ denied).

111. *Id.* at 74-75. This is consistent with the majority of decisions from other jurisdictions. A. WINDT, *INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSUREDS & INSURERS*, § 4.14, at 129 (1982 & Supp. 1984). Other jurisdictions have found that the "legal obligation to pay as damages" involves terminology that has an accepted, technical meaning under the law. *Aetna Cas. & Surety Co. v. Hanna*, 224 F.2d 499, 503 (5th Cir. 1955). This term has been found to mean a form of *pecuniary* compensation for a loss, detriment, or injury to the person, property, or rights of others. *Id.* Some courts have suggested that ancillary relief in the form of restitution and disgorgement, even though similar in nature to "damages," cannot be considered to be damages and in fact involves traditional forms of equitable relief. *See, e.g., Haines v. St. Paul Fire & Marine Ins. Co.*, 428 F. Supp 435, 439 (D. Md. 1977); *Board of County Comm'rs v. Guarantee Ins. Co.*, 90 F.R.D. 405, 407 (D. Colo. 1981). *See also* Annot., *Liability Insurer—"Duty to Defend,"* 53 A.L.R.2d 1132 (1957). This view has not been universally accepted. *See, e.g., United States Aviex Co. v. Travelers Ins. Co.*, 125 Mich. App. 579, 336 N.W.2d 838 (1983); R. KEETON, *INSURANCE LAW: BASIC TEXT* § 7.6(a) (1971).

112. 774 S.W.2d at 74. The general rule for determining whether there is a duty to defend requires examination of the allegations contained in the complaint against the insured in comparison with the policy terms and conditions. 7C J. APPLEMAN, *INSURANCE LAW & PRACTICE* § 4683, at 42 (1979); A. Windt, *supra*, note 111, § 4.01, at 129. The Texas Supreme Court follows the rule that the duty to defend "is determined solely from the face of the pleadings and without reference to facts outside the pleadings." *Continental Sav. Ass'n v. United States Fidelity & Guar. Co.*, 762 F.2d 1239, 1243 (5th Cir. 1985); *Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 24-25 (Tex. 1965). Texas courts appear to have refused consideration of extrinsic evidence, although there are a small number of decisions suggesting some limited exception to this general rule of refusal. *See infra* discussion at note 113.

The determination of the duty to defend becomes more problematical in those jurisdictions where the courts permit without limitation the examination of extrinsic evidence or facts, not alleged or set forth in the pleadings, to determine whether a duty to defend exists. Some courts have recognized that extrinsic evidence may be utilized to create a duty to defend that would not otherwise exist under the strict complaint allegation rule. *See, e.g., Lassen Canyon Nursery, Inc. v. Royal Ins. Co. of Am.*, 720 F.2d 1016, 1017-18 (9th Cir. 1983); *American Motorist Ins. Co. v. Southwestern Greyhound Lines*, 283 F.2d 648, 649-50 (10th Cir. 1960); *Hardware Mut. Cas. Co. v. Hildebrandt*, 119 F.2d 291, 297-98 (10th Cir. 1941); *Texaco, Inc. v. Hartford Accident & Indem.*, 453 F. Supp. 1109, 1114 (E.D. Okla. 1978). A minority of courts have permitted the use of extrinsic evidence, contradicting the allegations in the underlying complaint or supplementing them, to establish that there was in fact no duty to defend. A. WINDT, *supra*, note 111, at 139. *See* 10 *INS. LITIG. RPTR.* 87-89 (April 1988). One commentator has stated that there are really only three "exceptions" to the rule that extrinsic evidence cannot be used offensively by the insurer to avoid "an otherwise existing duty to defend." A. WINDT, *supra*, note 111, at 139. The three exceptions are as follows: (1) facts that are not reflected in the complaint and which are unrelated to the merits and allegations in the underlying complaint take the case outside of coverage (such as the issue of whether the activity in question involved a business pursuit, whether the automobile involved in an accident was a covered vehicle, and the determination of whether the party sued is an insured); (2) a false allegation is made in the underlying complaint solely for the purpose of bringing the case within coverage and not for the purpose of actually stating a claim; (3) extrinsic evidence establishes that the damages sought by the claimant are not covered by the policy. *Id.* at 140-44. A lengthy discussion of these exceptions is set forth in 10 *INS. LITIG. RPTR.* 87-89 (April 1988) and 11

and therefore could not be considered in determining the duty to defend.¹¹³

INS. LITIG. RPTR. 189 (May 1989); see also Annot., "Liability Insurer — Duty to Defend," 50 A.L.R.2d 458, 497-504 (1956); A.L.R.2d Later Case Service at 203-207 (1987).

The expansion of the duty to defend has been greatest in those few jurisdictions that suggest that even if the complaint does not plead any covered claims, there is still a duty to defend if any possible causes of action or factual scenarios can be imagined by the insurer that could possibly be covered. This "clairvoyance" rule appears to have first been suggested in *CNA Cas. v. Seaboard Sur. Co.*, 176 Cal. App. 3d 598, 222 Cal. Rptr. 276 (1986). In that case, the court emphasized that the insurer should be compelled to defend where it "learns from the complaint, the insured, or other sources" facts that reveal that a case potentially within coverage could be made." 222 Cal. Rptr. at 278-80. In *CNA*, an antitrust action, the court found that the factual allegations could lead to unfair competition, malicious prosecution and defamation claims that would be covered, despite the fact the complaint did not allege such claims by name. *Id.* Furthermore, the court noted that it was still possible for the pleadings to be amended to raise such claims based on the facts alleged. *Id.*; accord *Little v. MGIC Indem. Corp.*, 649 F. Supp. 1460, 1467 (W.D. Pa. 1986) (holding that suit, while cast in terms of intentional acts, could ultimately have resulted in covered negligence finding, and, therefore, there was duty to defend). The *CNA* court recognized that not only was the insurer bound to consider these possibilities and extrinsic evidence showing coverage, but it also had a duty to investigate to uncover facts pertaining to the coverage issue. 222 Cal. Rptr. at 278-80. The court held that the insurer could not consider the extrinsic evidence if it showed the claims were not covered. *Id.*

The decision and approach in *CNA* has been severely criticized in California and throughout the country. Glad, King & Gains, *The Spandex Factor in Liability Policies: Stretching the Duty to Defend*, 10 INS. LITIG. RPTR. 258, 260-62 (Oct. 1988). In *Federal Ins. Co. v. Cablevision Sys. Dev. Co.*, 836 F.2d 54 (2d Cir. 1987), the court rejected *CNA*, holding that even though the complaint, permeated with allegations of intended acts and harm, suggested some facts of unintended harm, which would be covered, the court would not "recast the pleadings in order to find a claim covered by the . . . policy." *Id.* at 58. The court noted that *CNA* improperly disregarded the actual theory of recovery or cause of action pleaded. *Id.* (discussing a number of cases from New York and other jurisdictions rejecting the *CNA* approach). As *Federal* recognizes, the *CNA* approach is the antithesis of the "complaint allegation" rule: either the actual allegations control or they do not; there is no middle ground. The *CNA* approach both requires the insurer to be at the mercy of the third-party claimants' pleadings, and forces the insurer to investigate to find facts showing theoretical claims that could be brought and could be covered. Fortunately, courts applying Texas law, including the court in *Feed Store*, have refused to use this type of approach to the important and practical business of determining the duty to defend. See *Brooks, Tarlton, Gilbert, Douglas & Kressler v. U.S. Fire Ins.*, 832 F.2d 1358, 1367-68 (5th Cir. 1987) (Texas law) ("the proper question is not what could . . . successfully have [been] pled," but what was "in fact pled."). See generally *Baldwin v. Aetna Cas. & Sur. Co.*, 750 S.W.2d 919, 920-21 (Tex. App.—Amarillo 1988, writ denied) (pleadings permeated with "intentional" allegations could not be saved by broad allegations of nuisance, which could have raised negligence-type claim that would have been covered).

An even more limited minority of courts have held that exclusions may not be used to deprive a party of the obligation to defend. See, e.g., *Donelly v. Trans. Ins. Co.*, 589 F.2d 761, 765 (4th Cir. 1979). The few courts following this approach urge that the duty-to-defend is broader than the duty to pay; the courts have also found that the exclusions inadequately, or at least ambiguously, referenced the policy terms setting out the defense obligation. *Id.* at 768. This approach has been clearly rejected in Texas by *Brooks*, 832 F.2d at 1366, and *Labatt Co. v. Hartford Lloyd's Ins. Co.*, 776 S.W.2d 795, 800 (Tex. App.—Corpus Christi 1989, no writ), discussed *infra* note 121.

In *Brooks* the Fifth Circuit held that this approach was contrary to Texas law because it rendered meaningless the policy terms in the duty-to-defend clause. *Brooks*, 832 F.2d at 1366 ("[I]t is incongruous to say that the coverage provision modifies the duty to defend provision without reference to the exclusion provision"). As the court in *Brooks* noted, the Texas Supreme Court has made clear that "[a]n insurer is required to defend only those cases within policy coverage." *Id.* (quoting *Fidelity & Guar. Ins. Underwriters, Inc. v. McManus*, 633 S.W.2d 787, 788 (Tex. 1982) and numerous other Texas cases).

113. 774 S.W.2d at 74 (citing *Fidelity & Guar. Underwriters v. McManus*, 633 S.W.2d 787, 788 (Tex. 1982)). Texas law is somewhat confused as to the issues of whether and to what

The court noted that the mere allegation of a tort is not the "same as asking

extent extrinsic evidence may be used to determine the duty to defend. In *Trinity Universal Ins. Co. v. Bethancourt*, 331 S.W.2d 943, 945-46 (Tex. Civ. App.—Amarillo 1959, no writ), the court held that where there is a "conflict between the facts as alleged in the petition and the actual facts as they are known or are ascertainable by the insurer," extrinsic evidence may be considered in determining the duty to defend. In *Trinity*, the suit alleged the insured committed an intentional act; the insured gave a statement to the insurer that he in fact did no such thing. The court allowed consideration of extrinsic facts and permitted the consideration of facts dealing with the truth and validity of the claims against the insured. *Id.* at 944.

In *Travelers Ins. Co. v. Newsom*, 352 S.W.2d 888, 890-94 (Tex. Civ. App.—Amarillo 1961, writ ref'd n.r.e.), the same court that decided *Trinity* held that that decision was in error and refused to follow it, noting it was "against all the great weight of authority . . . in Texas and . . . in other jurisdictions." *Id.* at 894. The court noted that prior Texas cases refused to allow consideration of such evidence or require that the insurer "ascertain" the true facts before denying a defense. *Id.* at 890-91. The court emphasized that there was no language in the contract sufficient to support consideration of anything but the allegations. *Id.* at 893. The court held that if extrinsic facts could not be shown as a basis for denial of the duty to defend, then there was no logical reason they could be used to establish a duty to defend. *Id.* at 894.

The Texas Supreme Court appeared to leave no room for the use of extrinsic evidence in *Heyden Newport Chem. Co. v. Souther Gen. Ins. Co.*, 387 S.W.2d 22, 24-25 (Tex. 1965). The *Heyden* court cited *Newsom* with approval, noting the court was correct in its strict interpretation of Maryland Cas. Co. v. Moritz, 138 S.W.2d 1095 (Tex. Civ. App.—Austin 1940, writ ref'd). 387 S.W.2d at 25. Newport sought coverage as an additional insured under Pickering's policy because it had been previously sued as though it were legally responsible for Pickering's acts. Newport admitted that in actuality Pickering was not an agent. This was the extrinsic evidence in question that the *Heyden* court refused to consider. This is the strictest possible view of the complaint allegation rule. Some courts and commentators have drawn a narrow exception to the rule where the issue involves whether the party seeking a defense is even an insured; the rationale for the exception is that the insurer never contracted to "defend a complete stranger to the contract." A. WINDT, *supra* note 111, § 4.05, at 144-45; See Cooper & Huddleston, *supra* note 20, at 368 n.193.

Despite *Heyden* and *Newsom*, some bold decisions allowing the use of extrinsic evidence have been issued by Texas intermediate courts of appeals. In *Cook v. Ohio Cas. Co.*, 418 S.W.2d 712, 714, 714-715 (Tex. Civ. App.—Texarkana 1967, no writ), the underlying petition was not before the court. Extrinsic evidence in the form of affidavits was presented, showing that the actions of the insureds were excluded because they were driving the automobile of a resident of the same household. *Id.* at 714. The court held that consideration of the evidence was proper. *Id.* at 715. The court noted that after *Heyden*, the Houston court of appeals in *International Serv. Ins. Co. v. Boll*, 392 S.W.2d 158 (Tex. Civ. App.—Houston 1965, writ ref'd n.r.e.), had allowed consideration of evidence that the son of the insured for whom coverage was excluded was the only son of the insureds, and, thus, there was no duty to defend the underlying suit, which stated vaguely that it was against an unnamed son of the insured. *Id.* at 160-61. The *Cook* court reasoned that *Heyden* and *Boll* suggested that the "Supreme Court draws a distinction between cases in which the merit of the claim is the issue and those where the coverage of the insurance policy is in question." 418 S.W.2d at 715-16. The court added: "In the first instance the allegation of the petition controls, and in the second the known or ascertainable facts are to be allowed to prevail." *Id.*; see *Rowell v. Hodges*, 434 F.2d 926, 929-30 (5th Cir. 1970) (following *Cook* and related cases where issue was whether vehicle in accident was an insured vehicle); *Hartford Fire Ins. Co. v. Rainbow Drilling Co.*, 748 S.W.2d 262, 267 (Tex. App.—Houston [14th Dist.] 1988, no writ) (underlying petition and absence of extrinsic evidence of possession required finding that insurance was not available). The court held that despite *Heyden* and the subsequent writ history of *Boll* (writ refused, no reversible error), the decision in *Boll* was more on point and was therefore controlling. 418 S.W.2d at 715-16.

Cook was followed in *Gonzales v. American States Ins. Co.*, 628 S.W.2d 184, 186-87 (Tex. App.—Corpus Christi 1982, no writ). In *Gonzales* several defendants were sued for manufacturing, installing, supplying, and owning a product which injured the claimant. The court held that the issue of "ownership" was material in the underlying suit and had to be assumed to be true; thus, the court would not consider extrinsic facts showing that the insured did not own the product in determining if there was a duty to defend. *Id.* at 187. The court explained:

for a particular remedy."¹¹⁴ The court clearly held that forms of relief that could be, but were not, alleged based on the claims made would not meet the "complaint allegation rule," which the court aptly described as the "eight corners" rule.¹¹⁵ The court added that the allegations made to obtain injunctive relief involved "pleading a wrong," which was consistent with a claim for nothing more than equitable relief.¹¹⁶ Finally, the court held that to give the effect sought by the insured to the broad prayer for relief would eviscerate the complaint allegation rule and the policy language dealing with the duty to defend.¹¹⁷ The court reasoned that there would be no case and no allegation that would not be cured and brought within coverage as a result of the use of such broad and all-encompassing language in the prayer.¹¹⁸

Importantly, the *Feed Store* court rejected the insured's attempt to have the court apply a rule of strict construction to the underlying pleadings for purposes of determining whether there was a duty to defend.¹¹⁹ The court stated:

There is good reason to construe a printed form against its author, and the law encourages an insurance company to think carefully about its

Where the insurance company refuses to defend its insured on the ground that the insured is not liable to the claimant, the allegations in the claimant's petition control, and facts extrinsic to those alleged in the petition may not be used to controvert those allegations. But, where the basis for the refusal to defend is that the events giving rise to the suit are outside the coverage of the insurance policy, facts extrinsic to the claimants' petition *may be used* to determine whether a duty to defend exists.

Id. (emphasis added).

The reasoning in *Cook* appears sound. There is no good reason for allowing loose and immaterial statements made in the underlying complaint either to deprive an insured of a defense to which the actual facts show him or her to be entitled or to require the insurer to defend someone clearly not intended or entitled to be defended. In *Heyden* the allegations of an agency relationship and resulting vicarious liability were material to that suit; therefore, they had to be taken as true. Allowing the discovery and admission of extrinsic evidence to determine the duty to defend would result in dual trials of the same issue with the possibility of inconsistent results and the bizarre situation of an insured having to prove the claimant's case for vicarious liability against the insurer in order to obtain coverage and a defense. This situation would not be present in cases such as *Cook* and *Boll*. Proof of whether the drivers of the offending automobile were related to the named insured or proof that the party sued was the only son of the insured and therefore the subject of an exclusionary endorsement present no such possibility of conflict or inconsistent results. The logic of this approach is further exemplified by cases where a breach of the policy conditions for timely notice or to forward suit papers is alleged. Obviously, almost all facts pertinent to these issues are extrinsic, but no one would dispute that such defenses, if proved, would not abrogate the duty to defend, the complaint allegation rule notwithstanding.

114. 774 S.W.2d at 74. This is consistent with the admonition of the court in *Continental Cas. Co. v. Hall*, 761 S.W.2d 54, 55 (Tex. App.—Houston [14th Dist.] 1988, writ denied), that the courts must look to the "origin of the damages, not the legal theory asserted for recovery."

115. 774 S.W.2d at 75 (court characterized the unmade, but theoretically possible, claims as "invisible allegations").

116. *Id.*

117. *Id.*

118. *Id.* The approach of the court in reading the pleadings reflects the continuation of a trend in Texas lower court opinions giving a "common sense" and not a hypertechnical reading of the "complaint allegation" rule. See *Baldwin v. Aetna Cas. & Sur. Co.*, 750 S.W.2d 919, 921 (Tex. App.—Amarillo 1988, no writ) (broad allegations of intentional acts were superimposed on all alternative allegations), discussed in *Cooper & Huddleston*, *supra* note 20, at 360.

119. 774 S.W.2d at 75.

draftmanship. But it takes a great leap to transform this rule into one which construes a *third party's* pleadings strictly against the insurance company, a leap we simply cannot make.¹²⁰

This aspect of the court's opinion, while logically appealing, would appear to be in conflict with several prior Texas cases suggesting a rule of liberal construction of pleadings in applying the complaint allegation rule.¹²¹ The reasoning of the court could serve as an impetus for change and further development of this area of the law.

Products Hazard Exclusion. In *Labatt Co. v. Hartford Lloyd's Insurance Co.*¹²² the court interpreted the premises liability portion of the standard Texas commercial multi-peril policy.¹²³ The policy excluded coverage for bodily injury and property damage "arising out of the named insured's products or reliance upon a representation or warranty."¹²⁴

120. *Id.*

121. In *Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 26 (Tex. 1965), the court, quoting Annot., "Liability Insurer — Duty to Defend," 50 A.L.R.2d 458, 504 (1956), stated: "[I]n case of doubt as to whether or not the allegations of a complaint against the insured state a cause of action within the coverage of a liability policy sufficient to compel the insurer to defend the action, such doubt will be resolved in [the] insured's favor." The court added that "in considering such allegations, liberal interpretation of their meaning should be indulged." *Id.* At least one commentator has interpreted the rule in *Heyden* to be a rule of *contra proferentem*. Dohoney, *The Liability Insurer's Duty to Defend*, 33 BAYLOR L. REV. 451, 462 (1981). Nevertheless, the same commentator recognizes that the standard to be applied is an objective one. *Id.* at 463 (discussing *Sewer Constructors, Inc. v. Employers Cas. Co.*, 388 S.W.2d 20, 24 (Tex. Civ. App.—Houston 1965, writ ref'd n.r.e.) ("if there are allegations from which the 'reasonable reader' would conclude that coverage is involved, there will be a duty to defend)). The rule of "liberal construction" was again followed by the Texas Supreme Court without further explanation in *Aetna Cas. & Sur. Co. v. Southern Brokerage Co.*, 443 S.W.2d 45, 48 (Tex. 1969). Numerous Texas courts of appeals and the Fifth Circuit Court of Appeals (interpreting Texas law) have specifically found that in applying the complaint allegation rule the court should indulge the "most liberal interpretation" of the allegations of which they are susceptible and that doubts as to the import of the allegations are to be resolved in favor of the insured and coverage. See, e.g., *Continental Sav. Ass'n v. United States Fid. & Guar. Co.*, 762 F.2d 1239, 1243 (5th Cir. 1985); *Brooks, Tarlton, Gilbert, Douglas & Kressler v. U.S. Fire Ins.*, 832 F.2d 1358 (5th Cir. 1987); *Mary Kay Cosmetics, Inc. v. North River Ins. Co.*, 739 S.W.2d 608, 612 (Tex. App.—Dallas 1987); *Colony Ins. Co. v. HRK, Inc.*, 728 S.W.2d 848, 850 (Tex. App.—Dallas 1987); see also *St. Paul Ins. Co. v. Rahn*, 641 S.W.2d 276, 279 (Tex. App.—Corpus Christi 1982, no writ).

The opinion of the court in *Feed Store* appears to go too far in light of prior case law. The court did not have to go this far to reach the decision that it reached. The underlying suit in that case clearly did not allege "damages" as required by the policy. Thus, the case was pleaded in a way that clearly placed it outside of coverage. The rule of strict construction, even when used in the more familiar setting of construing the terms of the policy rather than a third-party's pleadings, cannot be invoked unless there is doubt or ambiguity. Where only injunctive relief is sought in the underlying petition, it cannot be said that it is reasonable to interpret the petition to allege "damages." The court correctly concluded that a broad closing prayer, after a particularized statement of the relief sought, was inadequate to create the type of "doubt" necessary under *Heyden* and the above cases to allow the rule of liberal construction to be applied. 774 S.W.2d at 74-75. This is the approach adopted by courts in other jurisdictions and applauded by commentators. See *supra* note 112.

122. 776 S.W.2d 795 (Tex. App.—Corpus Christi 1989, no writ).

123. This policy provides coverage for liability claims against the insured "arising out of the ownership, maintenance, or use of the insured premises, and all operations necessary or incidental to the business of the named insured conducted out of or from the insured premises." *Id.* at 797.

124. *Id.* at 798. The policy defined "products hazard" as follows:

"Products hazard" includes bodily injury and property damage arising out of the

The underlying suit against the insured involved allegations of negligence and gross negligence in the design, manufacturing, and marketing of certain food products consumed by the complaining party. The court rejected the insured's arguments that the negligence allegations fell outside of the "products hazard" exclusion.¹²⁵ The court emphasized that the bodily injury alleged in the underlying suit against the insured arose from the products of the insured.¹²⁶ The court also held that the marketing or failure to warn allegations also fell within the "products hazard" exclusion because the relevant inquiry under the exclusion is whether "the bodily injury, not the alleged tortious conduct, occurred on the insured premises."¹²⁷ The court added that the underlying suit was grounded on a *defect* in the products sold and did not simply involve a negligent omission "unrelated to any product defect."¹²⁸ The court added "a failure to warn claim will fall outside of the 'products hazard' exclusion only if it is based on something other than a defect in the products sold by the insured."¹²⁹ The court added that a "product defect" under Texas law can involve a "design defect which may have its inception in poor packaging or inadequate warnings."¹³⁰ The court rejected the reasoning of numerous courts from other jurisdictions in this regard.¹³¹ The court emphasized the difference in policy language in those cases and the one before it.¹³² Finally, the court rejected arguments by the insured that the use of an endorsement to include the "products hazard" exclusion caused an ambiguity in that it inadequately referred to whether the exclusion impacted upon the "duty to defend."¹³³ The court found that the statement in the endorsement that it modified listed portions of the policy, which in this case included the liability insurance coverage part in question, was effective to modify all provisions relating to this particular type of in-

named insured's products or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs away from premises owned by or rented to the named insured and after physical possession of such products has been relinquished to others.

Id. at 798 (emphasis by the court).

125. *Id.* at 799.

126. *Id.*

127. *Id.* (citing *Viger v. Commercial Ins. Co.*, 707 F.2d 769, 772 (3d Cir. 1983)).

128. *Id.* This aspect of the court's opinion reflects a meaningful step towards the mainstream of opinions from other jurisdictions. For a lengthy discussion of prior Texas law in this area and the law in other jurisdictions, see Cooper & Huddleston, *Annual Survey of Texas Law, Insurance Law*, 42 Sw. L.J. 389, 404-06 (1988).

129. 776 S.W.2d at 799 (citing *Viger*, 707 F.2d at 773).

130. *Id.* at 799-800.

131. *Id.* at 799; see *Scarborough v. Northern Assur. Co. of Am.*, 718 F.2d 130 (5th Cir. 1983); *Chancler v. American Hardware Mut. Ins. Co.*, 109 Idaho 841, 712 P.2d 542 (1985); *Templet v. Goodyear Tire & Rubber Co.*, 341 So. 2d 1248 (La. Ct. App. 1976); *Cooling v. United States Fid. & Guar. Co.*, 269 So. 2d 294 (La. Ct. App. 1972). The decision in *Cooling* was relied upon in part in *Colony Ins. Co. v. H.R.K., Inc.*, 728 S.W.2d 848, 851 (Tex. App.—Dallas 1988, no writ), for the proposition that the products hazard requires proof of a defect. The *H.R.K.* court specifically pointed out that there were allegations of negligence outside of the sale of a defective pistol, for example the allegation that the insured sold the pistol when it knew or should have known the purchaser was mentally unstable. *Id.* at 849. Thus, *H.R.K.* is consistent with *Labatt* despite the dispute over other aspects of *Cooling*.

132. 776 S.W.2d at 799.

133. *Id.* at 800.

jury, including the duty to defend claims.¹³⁴

*Board of Education Policy. Continental Casualty Co. v. Hall*¹³⁵ involved a suit for damages by two students injured during a tug-of-war at school. The court held that an exclusion for "bodily injury, sickness or death" in a board of education liability policy applied to claims made against the insured that it had infringed upon the constitutional rights of its students to a safe educational environment.¹³⁶ The court noted that the mere fact that the case was cast in terms of the deprivation of a constitutional right did not change the fact that the damages sought were excluded by the policy.¹³⁷ The court reasoned that the determination of the applicability of the exclusion must focus upon the "origin of the damages, not the legal theory asserted for recovery."¹³⁸ The court followed the recent decision of the Fifth Circuit Court of Appeals in *Continental Casualty Co. v. McAllen Independent School District*.¹³⁹ The court apparently rejected arguments that a broad allegation of an invasion of constitutional rights was sufficient to invoke coverage where the only damages alleged appeared to have involved physical injuries.¹⁴⁰

Broad Form Workmanship Exclusions. The Dallas court of appeals added one more layer of analysis to a growing body of law emanating from that court with respect to the proper interpretation of the workmanship exclusions and the broad form comprehensive general liability endorsement. In *Gar-Tex Construction Co. v. Employers Casualty Co.*¹⁴¹ the insured was a subcontractor hired to provide labor and equipment for the construction of a clearwell. The specifications for the work included methods to prevent water damage to the clearwell during the course of its construction. Pumps used to keep the excavation site dry broke down, and runoff water accumulated, causing damage to the clearwell. The insured repaired the damage and sought reimbursement for this expense from its liability insurer.¹⁴² The policy was a broad form comprehensive general liability insurance policy, which excluded coverage for property damage to "that particular part of any

134. *Id.* The court added that there is a strong public policy reason behind allowing the integration of provisions from different types of the policies, which is based on the necessary increase in premiums that would follow from separately drafted, individual coverages. *Id.*

135. 761 S.W.2d 54 (Tex. App.—Houston [14th Dist.] 1988, writ denied).

136. *Id.* at 55.

137. *Id.* at 56.

138. *Id.* This is an important principle that is often missed or ignored. For example, many insurers urge that a claim for breach of contract is not covered. If that claim seeks "property damage" in the form of consequential damages, then the claim would appear to be covered, absent other variations in the pleading of the claim that might invoke other exclusions or requirements that could bar coverage.

139. 850 F.2d 1044, 1056 (5th Cir. 1988).

140. 761 S.W.2d at 56. This approach is consistent with prior Texas law and reflects a rejection of the approach of some California courts to determine the duty to defend based on what theoretically could be plead based on the initial allegations. *See supra* discussion at note 112.

141. 771 S.W.2d 639, 640 (Tex. App.—Dallas 1989, writ denied).

142. *Id.* The approach to resolving the problem could have destroyed coverage. Under the "no-action" clause, the insured under a CGL policy may not settle a claim without actual trial or the consent of the insurer. *See generally* *Wright v. Allstate Ins. Co.*, 285 S.W.2d 376, 380 (Tex. Civ. App.—Dallas 1955, writ ref'd n.r.e.). This "no-action" clause policy defense does not, however, appear to have been raised in *Gar-Tex*.

property . . . upon which operations are being performed” and that the restoration, repair or replacement of which “has been made or is necessary by reason of faulty workmanship”¹⁴³

The insured argued that because no actual work was being performed on the clearwell at the time of the damage, there were no ongoing “operations” that would effectuate the exclusion. The court noted that it was undisputed that the work on the clearwell was incomplete and ongoing.¹⁴⁴ The court concluded that under the circumstances the possession and occupation of the clearwell and the precautionary structures at issue were a vital part of the insured’s carrying out its contractual obligations to do the work; thus, the “damage was sustained by property upon which operations were being performed by” the insured.¹⁴⁵

The *Gar-Tex* court added that even if the “operations” exclusionary language set forth in VI(A)(2)(d)(i) were not applicable, the additional exclusionary language in (iii) was applicable.¹⁴⁶ The court rejected arguments presented by the insured that there was no evidence of faulty workmanship on its part, reasoning that the subcontract obligated the insured as part of the specifications to take proper preventative measures to avoid water damage to the clearwell.¹⁴⁷ The court concluded that such a failure to follow specifications amounted to defective workmanship so as to invoke exclusion (iii).¹⁴⁸ The court rejected arguments that the work that failed, involving attempts to avoid water damage, was somehow separable from the damage to the clearwell itself.¹⁴⁹ The court held that the precautionary measures were not “divisible from the clearwell project.”¹⁵⁰ Therefore, the endorse-

143. 771 S.W.2d at 641. The policy exclusion stated in full:

“This insurance does not apply:

.....

(2) Except with respect to liability under a written side track agreement or the use of elevators

.....

(d) to that *particular* part of any property, not on premises owned by or rented to the insured,

(i) upon which operations are being performed by or on behalf of the insured at the time of the property damage arising out of such operations, or

(ii) out of which any property damage arises, or

(iii) *the restoration, repair or replacement of which has been made or is necessary by reason of faulty workmanship thereon by or on behalf of the insured*

Id. (emphasis added).

144. *Id.* at 642.

145. *Id.* The court clearly applied an “operations” exclusion to an event that occurred after normal working hours. The court reasoned that the operations were continuous because of the duty under the contract to provide the pumps and other safety measures. *Id.* This type of duty to take safety precautions could be found in almost every construction contract, and, thus, the scope of the exclusion could be greatly expanded by such an interpretation.

146. *Id.* (court continues to treat exclusion (iii) as not requiring the damage to occur solely during “operations”).

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.* at 644.

ment excluded recovery to that "particular part of the property with which the insured or its subcontractor had contact in causing the loss," which in this case was the clearwell itself, not simply the precautionary systems.¹⁵¹ The court distinguished the situation before it from *Travelers Insurance Co. v. Volentine*,¹⁵² where the actual work was truly divisible.¹⁵³ The *Gar-Tex* court also found that the "completed operations" exclusion, set forth in subsection VI(A)(3), was not applicable because "the damage occurred before operations had been completed."¹⁵⁴ The court distinguished *Mid-United Contractors, Inc. v. Providence Lloyds Insurance Co.*¹⁵⁵ on the basis that the portion of that decision relied upon by the insured in *Gar-Tex* involved "completed operations," which was not the case in *Gar-Tex*.¹⁵⁶ Interestingly, the court in *Mid-United*, as well as in *Dorchester Development Corp. v. Seiko Insurance Co.*,¹⁵⁷ appeared to clearly apply exclusion (iii) to "completed operations" situations.¹⁵⁸ Finally, the court in *Gar-Tex* recognized that the exclusions at issue were not ambiguous and that they involved "common usage in the construction industry."¹⁵⁹

Discrimination-Employment Exclusion. In *Aberdeen Insurance Co. v. Bovee*¹⁶⁰ the court held that the "employee" exclusion (j), which excludes claims for bodily injury to an employee of the insured arising out of and in the course of his employment, eliminated coverage for claims of employment discrimination.¹⁶¹ The trial court ruled that a claim for damages for emotional distress and mental anguish amounted to "bodily injury" as that term was defined by the policy.¹⁶² The court of appeals found no need to address this issue because even if the mental anguish claims amounted to bodily injury, such claims were subject to exclusion under the employee exclusion.¹⁶³ The court held that the discriminatory conduct fell within the course and scope of the employment of the claimant.¹⁶⁴ The court *sub silentio* found that claims for declaratory relief, permanent injunctive relief, claims for back pay and other employee benefits, and punitive damages were insufficient to

151. *Id.*

152. 578 S.W.2d 501, 502-04 (Tex. Civ. App.—Texarkana 1979, no writ). In *Volentine* the insured worked only on the valves of an engine; the entire engine was later destroyed. The court held that the exclusion applied only to the valves; the rest of the engine involved property "other than" the work product. *Id.* at 504.

153. 771 S.W.2d at 645.

154. *Id.*

155. 754 S.W.2d 824 (Tex. App.—Fort Worth 1988, writ denied).

156. 771 S.W.2d at 644-45.

157. 737 S.W.2d 380 (Tex. App.—Dallas 1987, no writ).

158. See *Cooper & Huddleston*, *supra* note 128, at 401 n.103. The discussion of *Mid-United* by the Dallas court in *Gar-Tex* is confusing, but it at least begins to hit upon the true purpose of exclusion VI(A)(2)(d)(iii), which was not intended to apply to "completed operations" losses. 771 S.W.2d at 642.

159. 771 S.W.2d at 642-43.

160. 777 S.W.2d 442 (Tex. App.—El Paso 1989, no writ).

161. *Id.* at 444.

162. Most general liability policies define the term "bodily injury" as "bodily injury, sickness, or disease . . ." D. DEY & S. RAY, *DRI: ANNOTATED COMPREHENSIVE GENERAL LIABILITY POLICY* 164 (1984).

163. 777 S.W.2d at 444.

164. *Id.*

invoke coverage.¹⁶⁵ The insured apparently urged that a defense should have been provided because of these additional allegations. At least one Texas court has clearly held that purely equitable relief, such as a declaratory judgment or a permanent injunction, does not invoke the insuring agreement of a general liability policy.¹⁶⁶ Furthermore, the claims for lost economic and employee benefits were apparently found to have involved a loss of intangible property rights, which would not fall within the definition of "property damage" included in most general liability policies.¹⁶⁷ Finally, neither the trial court nor the court of appeals addressed the issue of whether the discrimination claims in question might involve "intentional acts" and therefore fall outside of the definition of "occurrence," which requires that the injuries be neither intended nor expected from the standpoint of the insured.¹⁶⁸

Insolvency of Primary Carrier. The Fifth Circuit Court of Appeals, in *Harville v. Twin City Fire Insurance Co.*,¹⁶⁹ held that the insolvency of a primary carrier did not require the excess carrier to "drop down" for purposes of providing a defense and indemnity.¹⁷⁰ The policy in *Harville* provided: "The company will defend any claim or suit against the insured seeking damages on account of injury or damage to which this insurance

165. *Id.*

166. *Feed Store Inc. v. Reliance Ins. Co.*, 774 S.W.2d 73, 74-75 (Tex. App.—Houston [14th Dist.] 1989, writ denied), *discussed supra* notes 111-22.

167. *See Lay v. Aetna Ins. Co.*, 599 S.W.2d 684, 686 (Tex. Civ. App.—Austin 1980, writ ref'd n.r.e.) (lost profits and other forms of economic harm did not amount to property damage).

168. Courts have found a duty to defend discrimination claims in the face of intentional acts exclusions where the claim is for "disparate impact" as opposed to "disparate treatment." "Disparate impact" involves "employment practices that are facially neutral in the treatment of different groups but that in fact fall more harshly on one group than another and cannot be justified by business necessity." *International Bhd. of Teamsters v. United States*, 431 U.S. 324, 335-36 n.15 (1977). "Disparate treatment" is the situation in which the employer treats some people less favorably than others because of their race, color, religion, sex, or national origin. "Disparate impact" cases do not require proof of discriminatory motive; thus, such allegations are covered under coverage for "unintentional" acts. *Solo Cup Co. v. Federal Ins. Co.*, 619 F.2d 1178, 1186 (7th Cir. 1980). The Fifth Circuit Court of Appeals has described "disparate impact" discrimination cases as cases involving "practices, procedures, or tests neutral on their face, and even neutral in terms of intent." *Barnes v. Yellow Freight Sys., Inc.*, 778 F.2d 1096, 1100 (5th Cir. 1985) (quoting *Griggs v. Duke Power Co.*, 401 U.S. 424, 430 (1971)).

Where "disparate impact" is not involved, courts have found that damages flowing directly from wrongful or discriminatory termination are not unexpected or unintended and, thus, are not covered under the general liability coverage part. *See St. Paul Fire & Marine Ins. Co. v. Superior Ct.*, 161 Cal. App. 3d 1199, 1202, 208 Cal. Rptr. 5, 7 (1984) (where termination of employment was purposeful, no coverage existed under policy insuring only claims due to "accidental event"); *Mary & Alice Ford Nursing Home, Inc. v. Fireman's Ins. Co.*, 86 A.2d 736, 446 N.Y.2d 559, *aff'd*, 57 N.Y.S.2d 883 (1982) (if plaintiff was discharged from employment due to disabilities, resulting injuries were not unexpected or unforeseen, and there was no accident within the meaning of general liability policies). Courts have been liberal in reading a potential disparate impact claim into discrimination causes of action to find a duty to defend. *See Solo Cup*, 619 F.2d at 1184. *See also Peer & Mallen, Insurance Coverage of Employment Discrimination and Wrongful Termination Actions*, 54 DEF. COUNS. J. 454 (Oct. 1987).

169. 885 F.2d 276 (5th Cir. 1989).

170. *Id.* at 278-79.

applies and which no underlying insured is obligated to defend . . .”¹⁷¹ The court noted that it was undisputed that if the primary carrier had been solvent, it would have been “obligated to provide a defense.”¹⁷² The court relied on its prior decisions in *Mission National Insurance Co. v. Duke Transportation Co.*¹⁷³ and *Continental Marble & Granite v. Canal Insurance Co.*¹⁷⁴ in reaching its decision, noting that the reasoning of those cases, although based on somewhat different policy language, was equally applicable to the case before it.¹⁷⁵ According to the court, excess insurance reflects an attempt by insurers “to provide inexpensive insurance with high policy limits by requiring the insured to contract for primary insurance with another carrier.”¹⁷⁶ The ability to provide such inexpensive insurance is also dependent upon the requirement that the insured obtain primary coverage that will provide a defense to the insured.¹⁷⁷ To impose the burden of the primary carrier’s insolvency on the excess carrier would lead to excess carriers requiring extensive scrutiny of the financial well-being of the primary insurer before issuing a secondary excess policy.¹⁷⁸ The court concluded that to require the excess carrier to “drop down” because of the insolvency of the primary carrier would be in effect to “re-write the excess liability policy” and to make the excess carrier an insurer not only for the insured but also for its primary insurer’s insolvency.¹⁷⁹

The court further held that because the excess carrier had no duty to defend, the insured’s failure to comply with the “no action” clause¹⁸⁰ was not excused.¹⁸¹ The court noted that the requirements of the “no action” clause are excused only where there has been an “erroneous” refusal to defend by the insurer.¹⁸² Because there was no duty to defend there could be no duty

171. *Id.* at 278. The courts have placed great emphasis upon the specific language utilized in the excess policy in determining whether the excess insurer has an obligation to “drop down.” An extensive discussion of this issue is presented in Cooper & Huddleston, *supra* note 20, at 362 n.137. The particular language at issue in *Harville* would appear to be different from the language previously addressed by the courts. 885 F.2d at 278.

172. 885 F.2d at 278.

173. 792 F.2d 550, 551-52 (5th Cir. 1986) (insolvency of primary carrier did not mean that underlying claim was not “covered” by that policy as required by excess policy terms).

174. 785 F.2d 1258, 1259 (5th Cir. 1986) (insolvency of primary carrier did not make that coverage “inapplicable” as required under excess policy as a predicate to “dropping down”).

175. 885 F.2d at 278-79.

176. *Id.* at 278.

177. *Id.* at 279.

178. *Id.* The court observed: “The insurance world is complex enough; to impose this additional burden on companies such as [the excess carrier] would only further our legal system’s lamentable trend of complicating commercial relationships and transactions.” *Id.* (quoting *Continental*, 785 F.2d at 1259).

179. *Id.*

180. This clause provided:

No action shall lie against the Company unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this policy, nor until the amount of the insured’s obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the Company.

Id.

181. *Id.*

182. *Id.*

of good faith and fair dealing that would support a tort action against the excess insurer.¹⁸³

Business Pursuits Exclusion. In *Burt v. Aetna Casualty & Surety Co.*¹⁸⁴ the court applied the standard homeowner's liability exclusion for "business pursuits."¹⁸⁵ The summary judgment evidence before the court established that the insured provided regular and continuous day care for the claimant's injured child "in exchange for an agreed, regular monetary compensation."¹⁸⁶ The claimants apparently had never had a social relationship with either the insured or her husband. In addition, the injury to the child was apparently the result of his having been violently shaken, which could only have occurred directly in the course of the business pursuit of providing day care services. Accordingly, the court held that the exclusion applied as a matter of law.¹⁸⁷ The court stated that procedurally the insurer carried its burden of proof on summary judgment by properly pleading the exclusions and proving the policy terms; at this point, the burden shifted to the non-movant insured to establish that "the loss was not attributable to the pleaded exclusion."¹⁸⁸ The court rejected late filed affidavits from the insured as well as statements not supported by the record indicating that the insured was not licensed as a day care operator, had not advertised as such, had no special training, and did not maintain business records.¹⁸⁹

III. AUTOMOBILE INSURANCE

Underinsured Motorist Coverage. In *Stracener v. United Services Automobile Association*¹⁹⁰ the Texas Supreme Court drastically rewrote the framework of underinsured motorist coverage. The issue presented to the court involved a conflict between two courts of appeals as to whether the limits of separate underinsured motorist policies can be "stacked" for the purpose of determining whether an insured tortfeasor is "underinsured." The First District court of appeals sitting in Houston had held that inter-policy stacking was not permissible with respect to underinsured coverage.¹⁹¹ The San Antonio court of appeals, however, reached the opposite conclusion in *United Services Automobile Association v. Hestilow*.¹⁹² The Texas Supreme Court, faced with a clear choice between these two interpretations, ignored both and adopted an approach not even argued by the parties.

The conflict between the courts of appeals in *Stracener* and *Hestilow* cen-

183. *Id.* at 279-80.

184. 720 F. Supp. 82, 84-85 (N.D. Tex. 1989).

185. This exclusion provides that coverage shall not apply: "To any business pursuits of an insured except activities therein which are ordinarily incidental to nonbusiness pursuits." *Id.* at 83.

186. *Id.*

187. *Id.* at 84.

188. *Id.* at 85.

189. *Id.*

190. 777 S.W.2d 378 (Tex. 1989).

191. *Stracener v. United Servs. Auto. Ass'n*, 749 S.W.2d 158, 160 (Tex. App.—Houston [1st Dist.] 1988).

192. 754 S.W.2d 754, 757-59 (Tex. App.—San Antonio 1988).

tered on whether the legislature had intended that insureds could stack all available underinsured policies in determining whether a tortfeasor was an underinsured motorist.¹⁹³ The Texas Supreme Court, however, never addressed the issue of legislative intent regarding stacking of coverages. Rather, the court gave article 5.06-1(2)(b)¹⁹⁴ a very expansive reading, which in effect circumvented the stacking issue. The court held that, in determining whether a tortfeasor is underinsured, payments made by the tortfeasor's liability insurer to the claimant must be deducted from the tortfeasor's limits of liability.¹⁹⁵

The Texas Supreme Court focused on the phrase "reduced by payment of claims" found in article 5.06-1(2)(b).¹⁹⁶ The court concluded that the "reduced by payment of claims" provision is not limited to payments made to "others," but includes claims made by the underinsured motorist as well.¹⁹⁷ Thus, in determining the issue of whether a tortfeasor is "underinsured," the liability limits of the tortfeasor's insurance policy are reduced by payments the tortfeasor's liability insurer has made to the beneficiary of the underinsured policy.¹⁹⁸

The Texas Supreme Court overruled the decisions of a number of courts of appeals.¹⁹⁹ The court expressly disagreed with the language in *Muller v. Allstate Insurance Co.*,²⁰⁰ stating that the purpose of underinsured motorist coverage is to guarantee that an insured injured by a tortfeasor carrying liability insurance with limits less than those mandated by statute, or that have been reduced by payments to other claimants in the same accident, will receive no less than the insured would have received had the tortfeasor been fully covered in relation to the claimant's underinsured motorist coverage.²⁰¹ Instead, the Texas Supreme Court read the legislative purpose underlying the act very broadly as to protect the insured's right to recover his or her actual damages.²⁰² With this very expansive reading, the Texas Supreme

193. *Stracener*, 749 S.W.2d at 159; *Hestilow*, 754 S.W.2d at 761.

194. TEX. INS. CODE ANN. art. 5.06-1(2)(b) (Vernon 1981).

195. 777 S.W.2d at 383.

196. TEX. INS. CODE ANN. art. 5.06-1(2)(b) (Vernon 1981). The full text of that article provides:

The term "underinsured motorist vehicle" means an insured motor vehicle on which there is valid and collectable liability insurance coverage with limits of liability for the owner or operator which were originally lower than, or had been reduced by payment of claims arising from the same accident to, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy.

Id.

197. 777 S.W.2d at 383.

198. *Id.*

199. *Tatum v. Mid-Century Ins. Co.*, 730 S.W.2d 41 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.); *Geisler v. Mid-Century Ins. Co.*, 712 S.W.2d 184 (Tex. App.—Houston [14th Dist.] 1986, writ ref'd n.r.e.); *Infante v. Texas Farmers Ins. Co.*, 640 S.W.2d 321 (Tex. App.—Beaumont 1982, writ ref'd n.r.e.); *Muller v. Allstate Ins. Co.*, 627 S.W.2d 775 (Tex. App.—Houston [1st Dist.] 1981, no writ); *American Gen. Fire & Cas. Co. v. Oestreich*, 617 S.W.2d 833 (Tex. Civ. App.—Eastland 1981, no writ).

200. 627 S.W.2d 775 (Tex. App.—Houston [1st Dist.] 1981, no writ).

201. *Id.* at 777.

202. 777 S.W.2d at 382.

Court then construed article 5.06-1(5)²⁰³ as reducing the claimant's *damages* by the amount recovered from the tortfeasor's insurer rather than reducing the *limit of liability* of the underinsured coverage.²⁰⁴ In reaching this holding, the court relied on the fact that the "reduced by" clause of the statute is separated from the remainder of the provisions in section (5) by a comma.²⁰⁵ Through this comma, the court was able to create an ambiguity that it resolved in favor of the claimant pursuant to the earlier found broad underlying intent of the statute.²⁰⁶

Because the liability insurers for the tortfeasors in the cases before the court had paid out their full limits of liability to the claimants,²⁰⁷ the tortfeasors in effect became "uninsured motorists." Therefore, the court did not need to reach the stacking issue that the two courts of appeals had decided differently. By choosing to resolve the stacking issue in this manner, the court announced a rule that changed the face of all underinsured motorist cases.

The court's opinion uses the "purpose" of the underinsured motorists provisions both to find an ambiguity in section (5) and to resolve that ambiguity. In determining the "purpose," the court looked initially to section 5.06-1(1).²⁰⁸ The court's quotation to this section deletes significant portions of the section. The provision states that the minimum standards it requires are the Financial Responsibility Act limits.²⁰⁹ It does not state, as the court suggests, that the purpose of the statute is full compensation for all actual damages in all cases.

The court also looked briefly to section 5.06-1(2)(b), which defines "underinsured motor vehicle" as follows:

The term "underinsured motor vehicle" means an insured motor vehicle on which there is a valid and collectible liability insurance coverage with limits of liability for the owner or operator which were originally lower than, or have been *reduced by payment of claims arising from the same accident to*, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy.²¹⁰

The court emphasized in its opinion "reduced by the payment of claims."²¹¹

203. TEX. INS. CODE ANN. art. 5.06-1(5) (Vernon 1981). The full text of that provision provides:

The underinsured motorist coverage shall provide for payment to the insured of all sums which he shall be legally entitled to recover as damages from owners or operators of underinsured motor vehicles because of bodily injury or property damage in an amount up to the limit specified in the policy, reduced by the amount recovered or recoverable by the insurer of the underinsured motor vehicle.

Id.

204. 777 S.W.2d at 383.

205. *Id.*

206. *Id.*

207. The opinion does not reveal whether the underinsured insurer consented to the settlements between the claimants and the tortfeasors.

208. 777 S.W.2d at 382-83.

209. TEX. INS. CODE ANN. art. 5.06-1(1) (Vernon 1981).

210. *Id.*, § 5.06-1(2)(b) (emphasis added).

211. 777 S.W.2d at 381.

The court then concluded: "Nothing contained in this statutory definition limits claims to those made by 'others' . . ." ²¹² This analysis ignores the language in section (2)(b) requiring a reduction "by payment of claims arising out of the same accident." ²¹³ The use of the plural "claims" and the reference to the "same accident" make clear that the reference was to claims other than the claim of the particular insured in question.

This is made even more clear by section (5). The available limits are to be reduced by payments made by the tortfeasors' liability insurer. Thus, such payment could not be a section (2)(b) "payment of claims arising out of the same accident." The court ignored section (5) and therefore failed to construe the statute as a whole to determine its meaning. Instead, the court seized upon one piece of section (2)(b) and used it in isolation to determine the purpose of the statute and thus to create an ambiguity in section (5).

The court's interpretation of the purpose and scope of the statute finds no support in the legislative history. The court noted that the initial objective of the uninsured motorist provisions was to protect motorists from "financial loss caused by negligent, financially irresponsible motorists." ²¹⁴ This does not mean that the protection intended was all-encompassing and not subject to limits. The court's interpretation alters the perspective clearly established by the legislature of comparing the tortfeasor's available limits of liability and the underinsured limits of the victim's policy to the victim's actual damages and underinsured limits of liability. If the legislature had intended such a system, it could have easily used clear language such as the court's holding in *Stracener*: "[A] negligent party is underinsured whenever the available proceeds of his liability insurance are insufficient to compensate for the injured party's actual damages." ²¹⁵ This holding only too clearly points out the words the court was forced to add to section (2)(b) to achieve the desired result. Numerous legislatures intending such a result have used specific language similar to that used by the court in its opinion in this case. ²¹⁶ The Texas Legislature used no such language and intended no such result.

The court asserts that its construction of section (5) was necessary to achieve consistency with its prior decisions in *Americal Liberty Insurance Co. v. Ranzau* ²¹⁷ and *American Motorists Insurance Co. v. Briggs*. ²¹⁸ Both decisions deal with the use of "other insurance" provisions to reduce the available uninsured motorists coverage under two clearly invoked policies.

212. *Id.* at 383.

213. *Id.* (emphasis added.)

214. 777 S.W.2d at 382.

215. *Id.* at 380.

216. *See, e.g.*, ALA. CODE § 32-7-23(4) (1975); ARIZ. REV. STAT. ANN. § 20-259.01(E) (1989); HAW. REV. STAT. § 431:10C-103(22) (1989); KY. REV. STAT. ANN. § 304.39-320 (1981); MASS. GEN. LAWS ANN. ch. 175, § 113L(2) (West Supp. 1986); MINN. STAT. ANN. § 65B.43 (West 1989); NEV. REV. STAT. ANN. § 687B.145(2) (1986); OKLA. STAT. ANN. tit. 36, § 3636(c) (West Supp. 1985); PA. CONS. STAT. ANN. § 1702 (1989); R.I. GEN. LAWS § 27-7-2.1 (1989); S.C. CODE ANN. § 56-9-831 (Supp. 1985); S.D. CODIFIED LAWS ANN. § 58-11-9.5 (Supp. 1986); WASH. REV. CODE ANN. § 48.22.030(1) (Supp. 1986).

217. 481 S.W.2d 793 (Tex. 1972).

218. 514 S.W.2d 233 (Tex. 1974).

The court in those cases clearly held that the "other insurance" clauses were inapplicable because they were not reductions authorized under the statute.²¹⁹ As noted by the court of appeals in *Geisler v. Mid-Century Insurance Co.*,²²⁰ these *uninsured* motorist "other insurance" clause cases are inapplicable to *underinsured* cases involving a reduction based on payment by the tortfeasor's liability insurer to the victim-insured because such a reduction is *expressly authorized* by section (5). Thus, *Ranzau* and *Briggs* simply cannot be used as a justification for the construction imposed by this court on section (5). These cases do make clear that the court is legally and logically compelled to interpret section (5) so as to eliminate the reduction provision before *Ranzau* and *Briggs* would ever be facially similar. These decisions do not serve as justification or operative tools for what the court did in interpreting section (5); they merely suggest the result to be reached when section (5) is eliminated.

The court erroneously held that the use of a comma preceding the reduction clause created an ambiguity.²²¹ The court did not explain how the presence of the comma resulted in more than one reasonable construction of the meaning of section (5). The use of the comma is consistent with and is in no way contrary to the doctrine of last antecedent, as suggested by the court. No rule of grammar or any other rule permits, much less mandates, a modifying clause to modify anything other than the words or clauses immediately preceding it.

The Texas Code Construction Act mandates that "[w]ords and phrases shall be read in context and construed according to the rules of grammar and common usage."²²² The doctrine of "last antecedent" is an accepted rule of grammar and common usage used to determine intent, not to distort it.²²³ As the court has previously stated, "[i]f Parliament does not mean what it says, it must say so."²²⁴

Section (5) sets forth a formula for determining the available limits for underinsured motorist coverage:

The underinsured motorist *coverage* shall provide for *payment* of all sums *which* he shall be legally entitled to recover as *damages* from owners and operators of underinsured motor vehicles . . . *in an amount* up to the limit specified in the policy, *reduced* by the amount recovered or recoverable from the insurer of the underinsured motor vehicle.²²⁵

The term "damages" that the *Stracener* court found to be modified by the "reduced" clause is itself a part of a clause ("which he shall be . . . entitled to recover as damages") modifying "all sums." Thus, the court rejected the rules of grammar and the doctrine of last antecedent to hold that a modifying clause modifies not a subject or object of the sentence but another modi-

219. *Briggs*, 514 S.W.2d at 236; *Ranzau*, 481 S.W.2d at 797-98.

220. 712 S.W.2d 184 (Tex. App.—Houston [14th Dist.] 1986, writ ref'd n.r.e.).

221. 777 S.W.2d at 383.

222. TEX. GOV'T CODE ANN. § 311.011 (Vernon 1988).

223. See *City of Corsicana v. Willman*, 147 Tex. 377, 216 S.W.2d 175 (1949).

224. *Brazos River Auth. v. City of Graham*, 163 Tex. 167, 182, 354 S.W.2d 99, 109 (1962).

225. TEX. INS. CODE ANN. § 5.06-1(5) (Vernon 1981) (emphasis added).

ying clause. This construction is not one that the legislature can be said to have intended. The error in the interpretation is made patently obvious when the provision is rewritten according to the court's interpretation:

The underinsured motorist coverage shall provide for payment to the insured of all sums which he shall be legally entitled to recover as damages, *reduced by the amount recovered or recoverable from the insurer of the underinsured motor vehicle*, from owners or operators of underinsured motor vehicles because of bodily injury or property damage in an amount up to the limit specified in the policy.

This construction is unreasonable. As reconstructed, the main purpose of the provision is to state that the limits of liability are the limits of liability. Under this interpretation, the "reduction" clause is bunched in with an ocean of modifying clauses. The result is that section (5) is given little or no purpose.

At least four courts of appeals, in five prior opinions, have rejected the interpretation adopted by the court in *Stracener*.²²⁶ From as early as 1981 until as late as 1988, the intermediate courts in this state have uniformly held that the "reduction clause" modified its immediate antecedent, the policy limits, and not the other modifying clause referring to "damages."

In the face of these well-defined rulings, the supreme court on at least three occasions refused writ with the notation "no reversible error." More importantly, the legislature, in four separate sessions during this period, took no action to alter these interpretations of the legislature's intent. Finally, the Texas Insurance Board adopted and approved policy forms consistent with these decisions. Now, twelve years after its passage, "underinsured motorists" has been completely redefined by the court.

By eliminating the effectiveness of the reduction clause, the court has made the applicability of underinsured motorist coverage the rule rather than the exception. It was intended to apply in the limited situation where an owner or operator did not have sufficient limits. This coverage was not intended to be a panacea covering all damages in all cases. Its role under the prior interpretation of the lower courts, though limited, was not nominal. Now, even if the tortfeasor has limits equal to the underinsured limits, coverage is still available. This approach ignores the limited role and function of this coverage. The premiums charged for this coverage were accordingly limited. They will most assuredly rise in response to the court's extraordinary and unprecedented expansion of a form of coverage interpreted to be quite limited during the twelve prior years of its existence. The court has in effect read the term "underinsured" out of the statute where damages exceed the limits. In every such situation, the tortfeasor becomes *uninsured* as a result of the court's elimination of the reduction clause. The legislature cannot be said to have done a purposeless act. Had the legislature intended the result adopted by this court, it could have easily altered the definition of "uninsured motorist" rather than creating a separate category of "underin-

226. See *supra* note 199.

sured motorist."²²⁷

The court placed great emphasis on the assertion that most Texas motorists would neither understand nor expect the amount of their underinsured coverage to be reduced or eliminated by the amount of the tortfeasor's coverage.²²⁸ This is a peculiar test that finds no approval in the rules of legislative interpretation or insurance contract construction.

The court gave no guidance as to how multiple insurers are to resolve the situation where multiple policies are invoked but the damages of the insured are less than the total of all the policy limits. The "other insurance" clause would appear to be a dubious source for resolution of this problem after *Ranzau*. Nevertheless, it may provide a proper and acceptable scheme for distribution where the full amount of damages is to be paid by the insurers en masse. At the very least, the requisite amounts due should be prorated based on the applicable policy limits. Recalcitrant underinsured carriers should be subject to suit for shares unpaid by them but paid by other insurers under either conventional or equitable subrogation.

In the guise of resolving the "stacking" issue, the court has in effect rewritten the provisions of the underinsured motorist statute. The impact of the *Stracener* holding will stretch much farther than the relatively small number of "stacking" cases arising in this state. Indeed, the holding of the court not only will directly impact every underinsured motorists claim made in the state of Texas, but will dramatically affect the premiums paid by every driver in the State of Texas for such coverage. In this manner, although the court may have intended to benefit insureds by way of its broad holding in this case, the court has in all probability priced underinsured motorists coverage out of the reach of the average insurance consumer. Moreover, since the statute by requiring written waiver of underinsured motorists coverage makes it difficult for insurance consumers to purchase the required liability insurance without obtaining underinsured motorists coverage, the court's broad holding will most likely adversely affect premiums of ordinary liability policies as well.

The Texas Supreme Court in *Stracener* overlooked a key provision of the underinsured motorist statute. Article 5.01-1(6) gives the underinsured motorist's carrier certain subrogation rights.²²⁹ Most importantly, by making

227. See, e.g., CONN. GEN. STAT. ANN. § 38.175c(a)(2) (West Supp. 1985); FLA. STAT. ANN. § 627.727(3)(b) (West 1984); GA. CODE ANN. § 33-7-11(b)(1)(D) (1982); ME. REV. STAT. ANN. tit. 24A, § 2902(1) (Supp. 1985); MD. INS. CODE ANN. art. 48A, § 541(c) (Supp. 1985); MASS. GEN. LAWS ANN. ch. 175, § 113L(2) (West Supp. 1986); MISS. CODE ANN. § 83-11-103(c)(iii) (Supp. 1985); N.H. REV. STAT. ANN. § 259:117 (1982); N.M. STAT. ANN. § 66-5-301(b) (1978); N.Y. INS. CODE LAW § 3420(f)(2) (Consol. 1985); TENN. CODE ANN. § 56-7-1202 (Supp. 1985); VT. STAT. ANN. tit. 23, § 941(f) (Supp. 1985); VA. CODE ANN. § 38.2-2206(B) (1986).

228. 777 S.W.2d at 383, 384.

229. TEX. INS. CODE ANN. art. 5.06-1(6) (Vernon 1981) provides:

In the event of payment to any person under any coverage required by this Section and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the

payment to its insured, the insurer is subrogated to the insured's rights to any settlement or judgment relating to the underinsured tortfeasor.²³⁰ Therefore, even if the underinsured insurer is not technically entitled to a set-off for the amounts paid by the tortfeasor's liability carrier under article 5.06-1(5), the underinsured insurer will nevertheless be able to achieve the same result through the exercise of its subrogation rights.²³¹ Thus, the underinsured insurer should be able to achieve through its subrogation rights the set-off that the courts of appeals had allowed it in the past.

*Harwell v. State Farm Mutual Automobile Insurance Co.*²³² is the first court of appeals opinion following *Stracener*. Harwell was injured when an automobile struck the motorcycle he was riding. Harwell settled with the automobile driver's liability insurer for the full amount of the limits of that policy, \$25,000.²³³

Harwell carried underinsured motorist insurance on his motorcycle in the amount of \$20,000.²³⁴ After his carrier, State Farm, refused to pay his underinsurance claim, Harwell sued State Farm under both his motorcycle and automobile policies.²³⁵ In a bench trial, the parties stipulated that Harwell suffered \$40,000 in bodily injuries and \$5,000 in medical expenses.²³⁶ Although the trial court found that Harwell was covered under his motorcycle policy, the court credited State Farm with an offset for the \$25,000 payment made by the liability insurer, thus holding that State Farm owed nothing under the underinsured motorist policy. The trial court also refused to stack the personal injury protection of Harwell's automobile policy on top of the \$2,500 State Farm had previously paid under the personal injury protection of the motorcycle policy.

The court of appeals reversed the judgment of the trial court, holding that

bodily injury, sickness or disease, or death for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer; provided, however, whenever an insurer shall make payment under a policy of insurance issued pursuant to this Act, which payment is occasioned by the insolvency of an insurer, the insured of said insolvent insurer shall be given credit in any judgment obtained against him, with respect to his legal liability for such damages, to the extent of such payment, but such paying insurer shall have the right to proceed directly against the insolvent insurer or its receiver, and in pursuance of such right such paying insurer shall possess any rights which the insured of the insolvent company might otherwise have had if the insured of the insolvent insurer had made the payment.

230. *Id.*

231. The procedure of subrogation post-*Stracener* might seem somewhat ludicrous. This is because the Texas Supreme Court did not read the underinsured motorist statute as a whole. The subrogation provision of TEX. INS. CODE ANN. art. 5.06-1(6) (Vernon 1981) is entirely consistent with the manner in which the entire act was construed by the courts of appeals pre-*Stracener* and with the act as the legislature most likely intended it to be read.

232. 782 S.W.2d 518 (Tex. App.—Houston [1st. Dist.] 1989, no writ).

233. The opinion does not reveal whether Harwell's insurer consented to his settlement with the tortfeasor.

234. Harwell carried uninsured motorists insurance on his automobile as well, but the opinion does not state the limits of that policy.

235. *Id.* at 519.

236. The opinion does not make clear whether the \$5,000 in medical expenses is included in or is additional to the \$40,000 in bodily injuries.

Harwell was covered under his underinsured policy to the extent his injuries exceeded the amount of coverage available to the tortfeasor.²³⁷ This holding was predicated solely on *Stracener*.²³⁸ Since the tortfeasor's liability insurer paid only \$25,000 of Harwell's \$40,000 in damages, the court of appeals held that Harwell was entitled to recover \$15,000 under the State Farm underinsurance policy.²³⁹

Harwell also argued on appeal that the trial court should have stacked his automobile personal injury protection on top of the \$2,500 paid pursuant to his motorcycle policy. The court of appeals, however, disagreed, holding that the personal injury protection coverage otherwise available under the automobile policy was excluded in the case before it.²⁴⁰ The exclusion relevant to the court's determination excluded personal injury protection coverage for bodily injuries sustained while a person seeking such coverage was occupying any motor vehicle (other than the subject automobile) owned by the insured. The court of appeals held that the exclusionary clause was valid and enforceable under current case law.²⁴¹

Underinsured Motorists Coverage—Persons Insured. In *Fulton v. Texas Farm Bureau Insurance Co.*²⁴² the court addressed the issue of whether an individual injured when he was struck by a car as he was standing outside of the car in which he had been a passenger was a "covered person" under an uninsured motorist policy covering the automobile in which he had been riding. Fulton had been a passenger in an automobile insured by Texas Farm Bureau. The driver of the insured vehicle, Bartek, got into an argument with the driver of another car. Both Bartek and Fulton had left Bartek's car in order to call the police after the driver of the other vehicle had intentionally collided with Bartek's car. The driver of the other car intentionally struck Fulton as he was walking across the parking lot.

Fulton sued Texas Farm Bureau under the uninsured motorists coverage of that policy. The trial court granted Texas Farm Bureau summary judgment on the basis that Fulton was not a "covered person" at the time of the accident inasmuch as Fulton was not occupying the car at that time. The court of appeals affirmed.²⁴³ The court focused on the requirement under the policy that a person must be "occupying" the insured car in order to be a "covered person."²⁴⁴ The court noted that the policy defined "occupying" as "in, upon, getting in, on, out or off."²⁴⁵ The court held that this definition requires there to be some causal relationship between the accident and the

237. 782 S.W.2d at 519.

238. *Id.* at 520.

239. *Id.*

240. *Id.* at 521.

241. *Id.* at 520 (citing *Beaupre v. Standard Fire Ins. Co.*, 736 S.W.2d 237 (Tex. App.—Corpus Christi 1987, writ denied); *Equitable Gen. Ins. Co. v. Williams*, 620 S.W.2d 608 (Tex. Civ. App.—Dallas 1981, writ ref'd n.r.e.); *Holyfield v. Members Mut. Ins. Co.*, 566 S.W.2d 28 (Tex. Civ. App.—Dallas), writ ref'd n.r.e., per curiam, 572 S.W.2d 672 (Tex. 1978)).

242. 773 S.W.2d 391 (Tex. App.—Dallas 1989, writ denied).

243. *Id.* at 392.

244. *Id.* at 393.

245. *Id.*

insured vehicle in order for a passenger to be considered a "covered person."²⁴⁶ Because Fulton was walking in the parking lot at the time he was struck, the court concluded that there was no causal connection between Fulton's injuries and Bartek's car, and, therefore, Fulton could not recover under the underinsured motorist policy.²⁴⁷

Uninsured Motorist Coverage—"Per Person" Limit. In *Eshtary v. Allstate Insurance Co.*²⁴⁸ the court of appeals affirmed a summary judgment in favor of an uninsured motorist insurer who refused to pay an uninsured motorist claim for a person not injured in an accident.²⁴⁹ Celia Eshtary's husband was killed in an automobile collision involving his vehicle and that of an uninsured motorist, but not involving Mrs. Eshtary. The Eshtary vehicle was covered by an Allstate uninsured motorist policy providing limits of \$20,000 per person injured in an accident. Allstate paid Mrs. Eshtary \$20,000 for the damages sustained by her husband, but denied her claim for \$20,000 based on her own alleged mental anguish caused by her husband's death.²⁵⁰

The court of appeals held that *McGovern v. Williams*²⁵¹ was controlling.²⁵² The court concluded that, because Mrs. Eshtary was not involved "in" the accident in question, she was not entitled to a separate limit of liability under *McGovern*.²⁵³ The court of appeals rejected Mrs. Eshtary's argument that *McGovern* was distinguishable in that *McGovern* involved loss of consortium whereas Eshtary's claim was for mental anguish.²⁵⁴ Mrs. Eshtary argued that, unlike loss of consortium, mental anguish constitutes "bodily injury."²⁵⁵ The court of appeals held that even if Mrs. Eshtary had been "in" the accident, the Texas Supreme Court's holding in *McGovern* was that "bodily injury" does not include mental anguish where the claim for mental anguish is asserted as a *derivative* claim arising only due to the injuries of another.²⁵⁶

"Identification Card." The court in *Black v. Victoria Lloyds Insurance Co.*²⁵⁷ addressed the effect of an insurer's issuance of an insurance "identifi-

246. *Id.*

247. *Id.* at 393.

248. 767 S.W.2d 291 (Tex. App.—Fort Worth 1989, writ denied).

249. *Id.* at 292-93.

250. The opinion does not make clear whether Mrs. Eshtary was claiming mental anguish as a bystander to her husband's death or as a beneficiary under the wrongful death statute. Compare *Freeman v. City of Pasadena*, 744 S.W.2d 923 (Tex. 1988) with *Sanchez v. Schindler*, 651 S.W.2d 249 (Tex. 1983).

251. 741 S.W.2d 373 (Tex. 1987).

252. 767 S.W.2d at 293.

253. *Id.* at 292.

254. *Id.* at 292-93.

255. The language from *McGovern* relied on by Mrs. Eshtary is as follows:

Mental anguish is a cause of action separate and distinct from loss of consortium. [Citation omitted.] In the present case, Mrs. McGovern neither alleged physical harm nor mental anguish. Her claim for loss of consortium, therefore, cannot constitute a claim of "bodily injury."

McGovern, 741 S.W.2d at 374-75.

256. 767 S.W.2d at 293.

257. 769 S.W.2d 949 (Tex. App.—Houston [14th Dist.] 1989, writ granted).

cation card" on the scope of coverage under an insurance policy. Daniel, an independent contractor, leased his truck to Wood Brothers. The terms of the lease required Daniel to drive his truck for Wood Brothers. The lease further provided that Wood Brothers' liability insurance would cover Daniel's truck and that payments for the premium would be deducted from Daniel's paychecks. Wood Brothers' insurer, Victoria Lloyds, issued Daniel a "cab card" and an "identification card."²⁵⁸

The Victoria Lloyds' policy covered Daniel's truck only while Daniel used the truck for Wood Brothers' business. While running a personal errand in his truck, Daniel's daughter seriously injured Black in an accident. After Black sued Daniel's daughter, Victoria Lloyds denied coverage to her on the grounds that she was not operating the truck in pursuit of Woods Brothers' business at the time of the accident. After Black obtained a judgment against Daniel's daughter; Black, Daniel, and Daniel's daughter pressed claims against Victoria Lloyds. The trial court granted summary judgment in favor of Victoria Lloyds on those claims.

On appeal the claimants argued that Victoria Lloyds had misrepresented the scope of coverage when it issued the identification card for the Daniel truck by stating in that card that the policy complied with the Texas compulsory automobile insurance laws. The court of appeals rejected that argument. The court noted that a liability insurer does not issue an identification card as a statement of the terms of the policy.²⁵⁹ Indeed, as the law does not require the issuance of such a card, the insurer issues it as a convenience to its insured.²⁶⁰ The court found that nothing about the card warranted that insurance coverage remain in effect for any given period of time. Rather, the card only represented that the minimum insurance was effective on the date of issuance.²⁶¹ The court held that since the Victoria Lloyds policy did comply with the compulsory automobile insurance laws as represented by the identification card, Victoria Lloyds made no misrepresentation by issuing the card.²⁶²

Assignments. In *State Farm County Mutual Insurance Co. v. Ollis*²⁶³ the Texas Supreme Court reversed a court of appeals opinion that held a liability insurer liable as a matter of law to the assignee of an injured party.²⁶⁴ In return for medical treatment made necessary by the accident, the claimant assigned to his doctor all of his rights to receive benefits otherwise payable to him by the other driver's liability insurer. The insurer subsequently paid the claimant \$9,000 in settlement of his claim. On appeal from a summary judgment entered in favor of the doctor, the insurer argued that the summary judgment was improper because the doctor had not obtained a judgment

258. The cab card was issued in compliance with the requirements of the Texas Railroad Commission and TEX. REV. CIV. STAT. ANN. art. 911b (Vernon Supp. 1990). 769 S.W.2d at 950.

259. 769 S.W.2d at 954.

260. *Id.*

261. *Id.*

262. *Id.*

263. 768 S.W.2d 722 (Tex. 1989).

264. *State Farm Mut. Auto. Ins. Co. v. Ollis*, 754 S.W.2d 781 (Tex. App.—El Paso 1988).

from the insured, which the insurer argued was a prerequisite to the legal responsibility of the insurer. The court of appeals held that the insured became legally obligated to pay the doctor upon execution of the settlement contract with him.²⁶⁵

The Texas Supreme Court, however, disagreed. The court found that neither the insurer nor its insured agreed to pay damages in conjunction with their settlement with the claimant.²⁶⁶ Therefore, under the terms of the State Farm policy, State Farm had no obligation to pay the doctor until the doctor obtained a judgment or an agreement requiring the insurer's insured to pay damages.²⁶⁷

Permissive User. The court in *U.S. Fire Insurance Co. v. United Service Automobile Association*²⁶⁸ addressed the issue of whether the automobile liability insurer had a duty to defend a passenger in the insured's automobile. Milliken was a passenger in a car being driven by Martin and owned by Martin's father. Both Milliken and Martin were injured when the car left the road and ran into a ditch. Milliken sued Martin for her injuries and Martin counterclaimed, seeking damages for his injuries as well.²⁶⁹

United Service, which had issued automobile and homeowner's liability policies to Milliken's father, filed a declaratory judgment action against Milliken and U.S. Fire, which had issued an automobile liability policy covering Martin's automobile, seeking to have the court determine which of the insurers, if any, had the duty to defend Milliken with respect to the counterclaim filed against her. U.S. Fire appealed from the trial court's grant of summary judgment in favor of United Service.

The court of appeals first addressed the issue of whether United Service had a duty to defend Milliken under the homeowner's policy. The policy contained a provision excluding from coverage conduct arising out of "[t]he ownership, maintenance, operation, use, loading, or unloading of: . . . any motor vehicle owned or (2) operated by or rented or loaned to any insured."²⁷⁰ Because of that exclusion, the court framed the issue as being whether Milliken was "using" or "operating" the Martin automobile at the time of the accident.²⁷¹ The court concluded that the fact that Milliken rode as a passenger in the automobile constituted a "use" of the automobile.²⁷² The court also concluded from the fact that Milliken allegedly grabbed the steering wheel that she was "operating" the automobile as well.²⁷³ Thus, the

265. *Id.* at 783.

266. 768 S.W.2d at 723.

267. *Id.*

268. 772 S.W.2d 218 (Tex. App.—Dallas 1989, writ denied).

269. Martin's counterclaim alleged that "suddenly and without warning [Milliken] grabbed the steering wheel of the car, causing it to leave the road, run into a ditch and seriously injure [Martin], who was a minor at the time of said accident.'" *Id.* at 220.

270. *Id.*

271. *Id.* at 221.

272. *Id.* (citing *State Farm Mut. Auto. Ins. Co. v. Francis*, 669 S.W.2d 424, 427 (Tex. App.—Houston [1st Dist.] 1984, writ ref'd n.r.e.); *Home Indem. Co. v. Lively*, 353 F. Supp. 1191, 1194 (W.D. Okla. 1972); *National Am. Ins. Co. v. Insurance Co. of N. Am.*, 74 Cal. App. 3d 565, 572, 140 Cal. Rptr. 828, 831 (1977)).

273. 772 S.W.2d at 221.

court held that coverage was not available under the homeowner's policy.²⁷⁴

The court next turned to the question of whether United Service had a duty to defend Milliken under the automobile policy it issued to her father. The parties did not contest the fact that if both automobile policies covered Milliken, U.S. Fire, which insured the automobile involved in the accident, would be the primary insurer, whereas United Service would be the excess insurer.²⁷⁵ Thus, if the U.S. Fire policy covered Milliken, only U.S. Fire would have a duty to defend with respect to the counterclaim brought against her.²⁷⁶

The court split the issue of coverage under the U.S. Fire policy into: (1) whether Milliken was "using" the automobile at the time of the accident, and (2) whether she was doing so "without a reasonable belief" that she was entitled to.²⁷⁷ On the issue of whether Milliken was using the automobile, the court concluded that its holding with respect to the exclusion under the homeowner's policy controlled.²⁷⁸

In determining whether Milliken had a reasonable belief that she was entitled to use the automobile, the court examined the allegations and the pleadings against Milliken.²⁷⁹ U.S. Fire argued that the allegation that Milliken grabbed the steering wheel "suddenly and without warning" negated her belief as a matter of law. The court of appeals, however, rejected that argument. The court noted that the phrase "suddenly and without warning" relates to the standpoint of the driver of the automobile rather than the subjective belief of Milliken as the passenger.²⁸⁰ The court held that the counterclaim contained no allegation establishing that Milliken had no reasonable belief that she was entitled to grab the steering wheel at the time of the accident.²⁸¹ The court concluded that, because the allegations did not suggest that Milliken had no reasonable belief that she was not entitled to grab the steering wheel, she was an insured under the U.S. Fire policy with respect to the claims brought against her.²⁸²

IV. PROPERTY INSURANCE

Proof of Loss. In *First Southwest Lloyds Insurance Co. v. MacDowell*²⁸³ First Southwest denied the fire claim of its insureds, James and Pauline MacDowell, alleging arson. Upon trial of the MacDowells' suit against First South-

274. *Id.* at 222.

275. *Id.*

276. *Id.*

277. *Id.*

278. *Id.* at 223.

279. *Id.*

280. *Id.* (citing *Argonaut Southwest Ins. Co. v. Maupin*, 500 S.W.2d 633, 635 (Tex. 1973)).

281. *Id.* at 223-24.

282. *Id.* at 224. In examining the allegations contained in the pleadings, the court considered itself bound to consider those allegations "in light of the policy provisions without reference to the truth or falsity thereof and without reference to what the parties know or believe the true facts to be." *Id.* at 223 (citing *Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co.*, 387 S.W.2d 22, 24 (Tex. 1965)).

283. 769 S.W.2d 954 (Tex. App.—Texarkana 1989, writ denied).

west, the jury found in favor of the MacDowells. On appeal, First Southwest claimed that the MacDowells' failure to secure jury findings on the proof of loss requirement precluded them from recovery on the policy. While nothing labeled "proof of loss" was ever submitted to the insurer, the MacDowells had furnished a complete inventory of items damaged or destroyed within one week of the fire, and First Southwest's investigator had examined the premises. The appellate court held that the information received by First Southwest was sufficient for the insurer to evaluate the claim and, therefore, that the MacDowells had substantially complied with the proof of loss requirement.²⁸⁴ Because the facts relating to the substantial compliance issue were undisputed, the court concluded that the issue was a question of law, and therefore, no jury finding was necessary.²⁸⁵

Proof of loss was also an issue in *Security National Insurance Co. v. Viles*.²⁸⁶ William and Mary Viles sued Security National and Trinity Universal insurance companies, as well as their adjusting company, for breach of policies and breach of the duty of good faith and fair dealing after they denied the Viles' claim for damage to the wood portion of their house's foundation caused by a water pan leak in 1980. Security National had paid an earlier claim for damage from the leak less than one month after the Viles filed a claim in 1980, but in 1986 an inspection pursuant to a contract to sell the house revealed additional damage. About June 30, 1986, the Viles contacted their insurance agent and turned in a written appraisal of the damage. They did not file a sworn proof of loss at that time. The adjuster offered \$3,000 to settle the claim, although the appraisal obtained by the Viles assessed cost to repair the damage at \$33,500. The sale of the house fell through, and the Viles later sold the house for \$27,400 less than the agreed sales price under the earlier contract. The jury found in favor of the Viles. On appeal, the insurers contended that the trial court had erred in failing to render a take-nothing judgment against the Viles on the grounds that the Viles failed to request a jury question on whether the Viles had substantially complied with the proof of loss requirements. Evidence at trial on proof of loss consisted of an August 26, 1986, request for a proof of loss form from the Viles' attorney and the signed form, erroneously dated October 6, 1985, reporting a loss between 1980 and June 21, 1986. The Fort Worth appellate court reversed the judgment on this point, holding that the Viles did not prove substantial compliance with the proof of loss requirement of ninety-one days.²⁸⁷ It further held that the \$3,000 offer, made within the required time period, did not prove waiver of the requirement as a matter of law.²⁸⁸ Thus, the appellate court reversed the judgment and rendered in favor of the insurers, concluding that the Viles' failure to submit a jury question regarding the proof of loss issue over the insurers' objections to this failure was

284. *Id.* at 959.

285. *Id.* at 959-60.

286. 773 S.W.2d 68 (Tex. App.—Fort Worth 1989, writ granted).

287. *Id.* at 70.

288. *Id.*

error.²⁸⁹

A federal district court granted a summary judgment against the insured with regard to the proof of loss requirement in *Holeman v. Director, Federal Emergency Management Agency*.²⁹⁰ The Federal Emergency Management Agency (FEMA) provided flood insurance to Donald Holeman under a policy that identified "proof of loss" as a sworn statement signed by the insured and required that the sworn proof be submitted within sixty days of the loss. While Holeman never submitted any sworn statement, his attorney did submit an unsworn letter. The agency had advised Holeman that the proof of loss could be submitted in letter form if the letter included all the information required in the policy paragraph relating to the proof of loss. This paragraph required that the insured sign and swear to the statement.²⁹¹ The court held that because procedural requirements in federal insurance policies must be strictly enforced, the insured's failure to provide a timely and complete sworn proof of loss statement excused the federal insurer's obligation to pay on an otherwise valid claim and precluded recovery on breach of contract claims.²⁹²

Examination Under Oath. In *State Farm General Insurance Co. v. Lawlis*²⁹³ Troy and Dorothy Caldwell filed suit against State Farm after fire destroyed their house, alleging that State Farm failed to pay under their homeowners policy and also alleging bad faith settlement practices. State Farm filed a plea in abatement, claiming that the Caldwells had not met express conditions precedent in the policy that required production of records and submission of the insured to examination under oath. The trial court denied the plea, and State Farm appealed. The examination had been scheduled on numerous occasions, but the Caldwells' attorney had cancelled each appointment. The Caldwells claimed that they had substantially complied with this policy requirement because Troy Caldwell had submitted to a four-hour recorded, unsworn, unsubscribed interview with State Farm's adjuster. The Beaumont court of appeals held that insurance policy provisions requiring the insureds to submit to examination under oath as a condition precedent to sustaining a suit on the policy were valid.²⁹⁴ The court also held that abatement was proper since the insurer had exercised its contractual right to require an examination under oath and no evidence existed to show that this

289. *Id.* at 71.

290. 699 F. Supp. 98 (N.D. Tex. 1988).

291. The Standard Flood Insurance Policy, Art. VIII, Paragraph I, 4, read: "Within 60 days after the loss, send us a proof of loss, which is your statement as to the amount you are claiming under the policy, signed and sworn to by you and furnishing us with the following information. . . ." *Id.* at 99.

292. *Id.*

293. 773 S.W.2d 948 (Tex. App.—Beaumont 1989, no writ).

294. *Id.* at 949. The policy provisions before the court read as follows:

If loss occurs . . . the Insured shall . . . if requested by the Company, submit to examination under oath and subscribe the same No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with

. . . .

Id.

right had been waived.²⁹⁵ The court also noted that the insurer's remedy was abatement, not the barring of the suit.²⁹⁶

Expert Testimony. In *Lundy v. Allstate Insurance Co.*²⁹⁷ the Lundys sued Allstate to collect under their fire insurance policy for serious fire damage to their home after Allstate refused to pay following an extensive investigation. Allstate defended by claiming that the Lundys intentionally set or procured the setting of the fire. Testimony showed that the Lundys had serious financial difficulties, had attempted to sell their house for two years, and had moved certain personal property out of the house about a week before the fire. The record also reflected that on the evening or afternoon before the fire a member of the Lundy family had purchased fuel similar to that later found in the house next to "pour patterns" that indicated that a flammable liquid had been poured on the floor and ignited. The trial court entered a judgment in favor of Allstate, and the Lundys appealed. They complained of the allowance of expert testimony as to the leading motives for arson and the allowance of testimony elicited by Allstate from Winona Lundy concerning her dismissal from her job after the fire. The Lundys also argued that the jury's affirmative answer to a special issue concerning any intentional act, design, or procurement of the fire on the part of the plaintiffs was not supported by the evidence or was against the overwhelming weight and preponderance of the evidence.²⁹⁸ The Beaumont appellate court affirmed, holding that the witness who testified as to the motives qualified as an expert and could testify as to motives for setting fires generally.²⁹⁹ It noted that the evidentiary rules permit expert testimony as to scientific, technical or other specialized knowledge, in the form of an opinion or otherwise, if that testimony will assist the trier of fact to understand the evidence and to determine a fact in issue.³⁰⁰ With regard to the single question and answer asked of Winona Lundy about the loss of her job,³⁰¹ the appellate court determined that, considering this testimony in relationship to the entire record, it did not amount to such a denial of the Lundys' rights that it was either reasonably calculated to, or probably did cause an improper judgment in the case.³⁰² As for the "no evidence" and "insufficient evidence" points, the appellate court stated that the large amount of circumstantial evidence had probative force to support the jury's verdict and that the result was not against the

295. *Id.*

296. *Id.*

297. 774 S.W.2d 352 (Tex. App.—Beaumont 1989, no writ).

298. *Id.* at 358. The jury question and answer were as follows:

Do you find from a preponderance of the evidence that the fire in question was intentionally caused by any act, design or procurement on the part of the Plaintiffs?

Answer: "We do" or "We do not."

Answer: "We do".

Id. at 353.

299. *Id.* at 357 (citing TEX. R. CRV. EVID. 702).

300. *Id.*

301. The question asked if Mrs. Lundy had worked for the Gem Jewelry Company since the date of the fire. She answered, "No, I have not worked for them." *Id.* at 358.

302. *Id.* (citing TEX. R. APP. P. 81(b)(1)).

overwhelming weight and preponderance of the evidence, especially in light of the fact that arson can be proved by circumstantial evidence.³⁰³

Subrogation and Indemnity. In *Baloise Insurance Co. of America v. Southwest Freight of San Antonio, Inc.*³⁰⁴ Baloise, Southwest Freight's inland transit insurer, alleged that Southwest Freight impaired Baloise's contractual right of subrogation under its policy by entering into an interchange agreement with American President Lines that required Southwest to fully indemnify American. The policy, under which the loss was undisputedly covered if no impairment existed, prohibited Southwest from entering into any special agreements with carriers, bailees, or others that would release them from common law or statutory liability. The court granted partial summary judgment in favor of Southwest against Baloise, holding that the effect of an interchange agreement was not to release American from liability, which would have been an impairment, but merely to place an indemnity obligation on Southwest.³⁰⁵ The insurer still had the right to make claims against American for defective equipment, but if it succeeded in its subrogation action, American would have a claim against Southwest under the interchange agreement.³⁰⁶ The court concluded that the insurer owed Southwest under the terms of the insurance policy.³⁰⁷

Mortgagee's Interest. Peoples National Bank demanded payment under a fire insurance policy issued to the Finches in *Peoples National Bank v. State Farm Fire & Casualty Co.*³⁰⁸ State Farm refused to pay the Finches, claiming the policy had lapsed for nonpayment of premium, and also refused to pay Peoples National Bank, the Finches' mortgagee. The bank filed suit and thereafter State Farm filed a motion for summary judgment on four grounds: (1) that the bank had suffered no financial loss, (2) that the Finches had continued to make monthly payments on their obligation to the bank, (3) that the bank admitted that any money it might receive in the suit would be given to Ronnie Finch, and (4) that there was no factual dispute with respect to the bank's damages claim. The bank's evidence in response to the motion included testimony that the destruction of the house by fire had put the bank in a deficient collateral position and that the bank had not received any notice of cancellation from State Farm prior to the loss. The trial court granted State Farm's motion for summary judgment, and the bank appealed. The Beaumont court of appeals reversed and remanded the case for trial, holding that the bank's response to the motion raised fact issues as to the amount of loss and the value of the remaining collateral.³⁰⁹ The court stated that in a case of injury to security, one of the objectives of insurance was to provide the mortgagee with additional security to restore the security to the

303. *Id.* at 358-59.

304. 698 F. Supp. 674 (S.D. Tex. 1988).

305. *Id.* at 675.

306. *Id.*

307. *Id.*

308. 772 S.W.2d 512 (Tex. App.—Beaumont 1989, writ denied).

309. *Id.* at 513.

status quo.³¹⁰

Arbitration. In *Triton Lines, Inc. v. Steamship Mutual Underwriting Association*³¹¹ the shipowners sued Steamship Mutual, an association of steamship owners that provided insurance, for its refusal to pay claims for the loss of a ship. The association's rules included a choice of English law and an arbitration requirement. After Triton refused to abide by the arbitration clause, the association moved to stay the lawsuit until the completion of arbitration. In holding that arbitration was required prior to consideration of the insurance contract questions by the district court, the court noted that the Federal Arbitration Act requires enforcement of an arbitration clause in maritime contracts, which include an insurance contract for a vessel between an American insured and a foreign insurer.³¹² Additionally, the court rejected Triton's argument that another federal statute³¹³ abandoned the field of insurance business regulation to the states, holding that resolution of a disputed claim was not the "business of insurance" for purposes of insurance regulation.³¹⁴

Receivership. In *Khalaf v. Odiorne*³¹⁵ the receiver for Pacific American Insurance Company sent written notice of rejection of the insured's fire claim by certified mail to the insured at an address given in the insured's proof of claim. The postal service returned the letter to the receiver, marked "no such number return to sender." The insured filed suit more than six months later. The receiver pleaded that the insured's assertion of her claim was barred by a provision of the Texas Insurance Code requiring suits on a claim to be filed in district court within three months after service of notice of the rejected claim.³¹⁶ The insured claimed that she filed suit within three months of her receipt of the actual notice of the rejection, which she had eventually received through her attorney. The district court granted summary judgment for the receiver, holding that service of the notice of rejection was effective upon mailing despite lack of receipt. The appellate court, comparing the language of the statute setting out the three-month deadline for filing suit with language in a related section specifying the procedure for the receiver to follow in acting on claims,³¹⁷ concluded that the legislature intended the mode of notification referred to in the filing deadline section to be the same as the notification spelled out in the latter section, which required notice "in a manner determined by the [receivership] court."³¹⁸ Because the receivership court's order appointing the receiver specified that mailing would be sufficient proof of notice, the court affirmed the summary judgment in favor of the receiver.³¹⁹

310. *Id.*

311. 707 F. Supp. 277 (S.D. Tex. 1989).

312. *Id.* at 278 (citing Federal Arbitration Act, 9 U.S.C. § 1 (1988)).

313. McCarran-Ferguson Act, 15 U.S.C. § 1011 (1982).

314. 707 F. Supp. at 279.

315. 767 S.W.2d 856 (Tex. App.—Austin 1989, writ denied).

316. TEX. INS. CODE ANN. art. 21.28, § 3(h) (Vernon Supp. 1990).

317. *Id.*, art. 21.28, § 3(a).

318. 767 S.W.2d at 858 (quoting TEX. INS. CODE ANN. art. 21.28, § 3(a)).

319. *Id.*

V. HEALTH, LIFE, AND ACCIDENT INSURANCE

Delivery of Application. *Wise v. Mutual Life Insurance Co.*³²⁰ involved the issue of whether a copy of a life insurance application must accompany the policy when it is delivered to the insured before the insurer can claim misrepresentations as a defense to coverage. In *Wise* the insured misrepresented the fact that he was undergoing alcohol and drug abuse treatment and had both cirrhosis of the liver and gastritis at the time he applied for coverage. The plaintiff, owner of and beneficiary under the policy, knew of these misrepresentations before he signed his name to the application. Mutual Life approved the application and forwarded a copy of the policy as well as a copy of the application to its agent for delivery to the plaintiff. The agent, however, did not deliver the application until after the insured's death.³²¹ Consequently, the court was compelled to analyze the 1951 amendments to article 21.35 of the Texas Insurance Code³²² to decide whether an insurer may use the misrepresentations of an insured as a defense to coverage when the policy at issue is a *life* insurance policy. Article 21.35, prior to the 1951 amendments, provided that every policy had to be accompanied by a written copy of the application for the insurance, as well as a copy of all questions asked and answered. This requirement, however, did not apply to life insurance policies.³²³

The court held that the addition in article 21.35 of the phrase "[e]xcept as otherwise provided in this code" and the substitution of "Articles 21.16, 21.17 and 21.19" in lieu of "foregoing articles"³²⁴ were material changes in the statute evidencing an expressed desire by the Texas Legislature not to exempt life insurance policies from a delivery requirement.³²⁵ Accordingly, the court granted the plaintiff's motion for summary judgment because Mutual Life could not use the misrepresentations by the insured on the applica-

320. 714 F. Supp. 822 (E.D. Tex. 1989).

321. The agent kept the policy in his possession in a file and merely forgot to deliver the policy and application to the owner. Additionally, the premium payments on the policy were kept current throughout the life of the policy.

322. TEX. INS. CODE ANN. art. 21.35 (Vernon 1981).

323. TEX. REV. CIV. STAT. art. 5049 (1911) (repealed 1978) (now TEX. INS. CODE ANN. ART. 21.35 (VERNON 1981)) provided as follows:

Every contract or policy of insurance issued or contracted for in this State shall be accompanied by a written, photographic or printed copy of the application for such insurance policy or contract, as well as a copy of all questions asked and answers given thereto. The provisions of the foregoing articles shall not apply to policies of life insurance in which there is a clause making such policy indisputable after two years or less, provided premiums are duly paid

324. Article 21.35 now provides, in part, as follows:

Except as otherwise provided in this code, every contract or policy of life insurance issued or contracted for in this State shall be accompanied by a written, photographic or printed copy of the application for such insurance policy or contract, as well as a copy of all questions asked and answers given thereto The provisions of *Articles 21.16, 21.17, and 21.19 of this code* shall not apply to policies of life insurance in which there is a clause making such policy indisputable after two (2) years or less, provided premiums are duly paid

TEX. INS. CODE ANN. art. 21.35 (Vernon Supp. 1990) (emphasis added).

325. 714 F. Supp. at 824.

tion as a defense.³²⁶

Misrepresentation on Application. In *American States Life Insurance Co. v. Monroe*³²⁷ American States refused to pay Monroe's beneficiaries upon her death because the application did not reveal that she suffered from scleroderma at the time of the application.³²⁸ On the application, Mrs. Monroe indicated that she suffered from "varicose veins, varicose ulcers, phlebitis, or a hernia" and that she had been treated for a condition "not recorded above."³²⁹ At trial, the jury failed to find that she misrepresented her health condition on the application.³³⁰

The court of appeals upheld the trial court and concluded that the evidence did not conclusively establish the elements of misrepresentation.³³¹ The court considered the fact that Mrs. Monroe indicated on the application various physical problems from which she had suffered as well as the fact that she had been treated by a physician for a condition not listed on the application.³³² Moreover, there was no conclusive showing that she even knew of her condition by name.³³³ Additionally, the court rejected American States' argument that the insured's truthful representation of her physical condition was a condition precedent to the policy becoming effective.³³⁴ The court noted that the Texas Insurance Code provides that, in the absence of fraud, statements made by the insured shall be deemed representations and not warranties.³³⁵

Application. When an application for insurance is attached to and made a part of the policy accepted and retained by the insured, the insured is conclusively presumed to know the contents of the application and to ratify any

326. *Id.* at 825.

327. 762 S.W.2d 633 (Tex. App.—Texarkana 1988, writ denied).

328. The insured paid premiums regularly until she died from respiratory failure due to scleroderma. *Id.* at 634.

329. *Id.*

330. The trial court submitted the following question on misrepresentation: "Do you find from a preponderance of the evidence that RUTHIE MAE MONROE made misrepresentations in the application for the insurance policy." *Id.* at 635. The issue which American States requested, but which was denied, provided: "Do you find from a preponderance of the evidence that Ruthie Mae Monroe deliberately misrepresented her physical condition to induce AMERICAN STATES LIFE INSURANCE COMPANY to issue the insurance at question?" *Id.* The court held that the more broad issue submitted was proper. *Id.* (citing *Island Recreational Dev. Corp. v. Republic of Tex. Sav. Ass'n*, 710 S.W.2d 551, 555 (Tex. 1986)). The rule in Texas is that to avoid payment on an insurance policy because of misrepresentation, the insurer must plead and prove that the insured knew or should have known that the representations were false and the representations were made with the intent of inducing the insurer to issue a policy. *Id.* at 635-36 (citing *Clark v. National Life & Accident Ins. Co.*, 145 Tex. 575, 579-80, 200 S.W.2d 820, 823 (1947); *Carter v. Service Life & Casualty Ins. Co.*, 703 S.W.2d 349, 352 (Tex. App.—Corpus Christi 1985, no writ); TEX. INS. CODE ANN. art. 21.16 (Vernon 1981)).

331. *Id.* at 636.

332. *Id.*

333. *Id.* Apparently, scleroderma was not one of the itemized illnesses and conditions appearing on the policy.

334. *Id.*

335. *Id.* (citing TEX. INS. CODE ANN. art. 3.44(4) (Vernon Supp. 1988); *Allied Bankers Life Ins. Co. v. De La Cerda*, 584 S.W.2d 529, 533 (Tex. Civ. App.—Amarillo 1979, writ ref'd n.r.e.)).

false statements therein.³³⁶ Further, this rule is applicable even though the insured is illiterate or unable to read or write in English.³³⁷ In *American National Insurance Co. v. Navarrete*³³⁸ the agent prepared the insured's application for a life insurance policy because the insured could not read or speak English. Although the insured told the agent who prepared the application that he was undergoing treatment for high blood pressure and chest pains, the agent completed the application to reflect that the insured was in good health. Less than a year after the preparation of the application and the issuance of a life insurance policy, the insured died as a result of cardio-respiratory arrest and a cerebral hemorrhage. Because of the relationship between the inaccuracy in the application and the cause of death, the insurer refused the beneficiary's claim for policy benefits. The beneficiary sued the insurer and obtained jury findings that the insured had truthfully answered the questions on the application, but that the agent had failed to accurately record these answers. The jury further found that the insured was in good health when the policy was issued. The insurer complained on appeal that the jury's finding that the insured was in good health was unsupported by either legally or factually sufficient evidence.

Based solely upon lay testimony that the insured was in good health except for high blood pressure problems, the court of appeals concluded that legally sufficient evidence supported the jury's verdict because it implied an affirmative answer subject to a condition.³³⁹ The court reasoned that because it could only consider evidence favorable to the jury's verdict, it was compelled not only to disregard the conditional aspect of the answer and all evidence of the insured's poor health, but also to only consider the implication that the insured was otherwise in good health.³⁴⁰

In considering the factual insufficiency question, however, the court found the jury's finding that the insured was in good health so contrary to the preponderance of the evidence as to be manifestly wrong and unjust.³⁴¹ The court noted that the insured had a chronic history of heart disease and hypertension and that the insured's brother testified that he did not believe the insured to be in good health.³⁴² Accordingly, the court reversed the judgment in favor of the beneficiary and remanded the case for a new trial.³⁴³

Lapse of Policy: No Duty to Inform. In *Shindler v. Mid-Continent Life Insurance Co.*³⁴⁴ the court held that neither an insurer nor its agent has a duty to notify the policyholder that the policy has lapsed for nonpayment of premiums.³⁴⁵ In *Shindler* the insured purchased life insurance policies that pro-

336. *Odom v. Insurance Co.*, 455 S.W.2d 195, 199 (Tex. 1970).

337. See 17 J. APPLEMAN, *INSURANCE LAW AND PRACTICE* § 9405 (West 1981); 7 G. Couch, *Couch on Insurance Second* § 35:213 (1985).

338. 758 S.W.2d 805 (Tex. App.—El Paso 1988, writ denied).

339. *Id.* at 808.

340. *Id.*

341. *Id.*

342. *Id.*

343. *Id.*

344. 768 S.W.2d 331 (Tex. App.—Houston [14th Dist.] 1989, no writ).

345. *Id.* at 333-34.

vided for automatic termination if the annual premium was not timely paid. Although the insured paid the initial premium, he paid no subsequent premium, and the policies lapsed. After the insurer refused his demand to reinstate the policies, the insured sued the agent and the insurer for misrepresentation on the theory that he had received correspondence indicating that the policies were still in effect when they had in fact been terminated for failure to pay the annual premium. Although the court recognized that in certain circumstances the agent has a duty to notify the insured that the premium is due,³⁴⁶ it held that an insurer has no legal duty to inform the insured of premiums due and owing unless the terms of the policy impose such a duty.³⁴⁷ With respect to agents, the agent is obligated to inform the insured of the nonpayment of premium only if the agent receives requests from the insurer to forward statements to the insured.³⁴⁸ The court declined, however, to impose this duty on the agent because the testimony did not clearly indicate that the agent had actually received such a request from the insurer.³⁴⁹ With respect to the causes of action for misrepresentation against both the agent and the insurer, the court held that although the correspondence in question could be misleading, it could not have been a legal cause of any damage to the insured because the letters were written long after the policies had expired, and thus, the insured was deemed to know of the lapse of his policies.³⁵⁰

Invalid Termination Provisions. While an insurer may terminate a policy for the nonpayment of premiums, it may not rely on any policy provision that establishes a date after which coverage is ineffective if the date falls within the period for which the premium is accepted by the insurer.³⁵¹ In *Barns v. Underwriting Members of Lloyds, London*³⁵² the insurer issued a policy to a college football player that provided coverage in the event an injury prevented the insured from signing a contract to play professional football. The policy, however, provided that if the insured signed a professional football contract, the policy terminated at that time and no premium would be refunded to the insured. Although the insured signed a contract to play professional football, the contract was subject to termination if the insured failed the team's physical examination. The insured suffered an injury shortly after signing this contract, and therefore, he failed to pass the team's

346. *Id.* at 333; *see also* *Kitching v. Zamora*, 695 S.W.2d 553, 554 (Tex. 1985) (agent must make reasonable attempts to keep insured informed about policy expiration where agent receives expiration information that is intended for insured).

347. *Shindler*, 768 S.W.2d at 333.

348. *Kitching*, 695 S.W.2d at 554.

349. *Shindler*, 768 S.W.2d at 334.

350. *Id.* at 334-35.

351. TEX. INS. CODE ANN. art. 3.70-7 (Vernon 1981) provides:

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which the premium has been accepted.

352. 866 F.2d 813 (5th Cir. 1989).

physical examination. When the insured sought to recover under the policy, the insurer refused payment on the ground that the policy was cancelled when the insured signed the contract to play professional football. The Fifth Circuit held the cancellation provision void under article 3.70-7 of the Insurance Code, which invalidates all policy provisions that would shorten the policy period.³⁵³ The Fifth Circuit also rejected the insurer's contention that this provision has no application to policies issued by a surplus lines insurer. Noting that the Insurance Code refers disjunctively to "Lloyds" or "any other insurer which by law is required to be licensed,"³⁵⁴ the court reasoned that by making Lloyds a class of insurers to which the provision applied, it was immaterial whether the Lloyds insurer was also licensed.³⁵⁵

Restitution. In *Lincoln National Life Insurance Co. v. Brown Schools, Inc.*³⁵⁶ the insurer under a group health insurance policy sought restitution from a hospital for the insurer's payment in excess of policy limits made on behalf of an insured. These overpayments were caused solely by the mistake of the insurer. Relying on the Nebraska Supreme Court decision in *Federated Mutual Insurance Co. v. Good Samaritan Hospital*³⁵⁷ the court held that overpayment to a third party, as opposed to the insured, could not be the subject of a claim for restitution if the third party materially changes its position in reliance on the payment.³⁵⁸ The court concluded that the hospital could not be held liable for restitution because it acquired standing analogous to that of a bona fide purchaser for value in that it rendered services to the insured in return for the sums paid by the insurer.³⁵⁹ Since there had been no unjust enrichment with respect to the hospital, it was not liable to the insurer for the amount of the overpayment pursuant to a contract to which it was not a party.³⁶⁰

Beneficiary Designation. In *Smith v. Jones*³⁶¹ the husband was the named insured in a life insurance policy under which benefits were to be paid to the wife. Shortly before the husband's death, the trial court rendered a judgment of divorce that terminated the wife's beneficial rights under the policy. Because the husband failed to change the named beneficiary designation prior to his death, however, the wife claimed the policy proceeds. A majority of the court of appeals concurred in the judgment that the wife take nothing on her claim.³⁶² One justice reasoned that because the wife did not appeal the divorce decree, she could not collaterally attack the effect of the order that deprived her of the benefit of the policy proceeds.³⁶³ The concurring justice pointed out that while the family court may award ownership of

353. *Id.* at 815.

354. *Id.*; see TEX. INS. CODE ANN. art. 3.70-1(C) (Vernon 1981).

355. 866 F.2d at 815.

356. 757 S.W.2d 411 (Tex. App.—Houston [14th Dist.] 1988, no writ).

357. 191 Neb. 212, 214 N.W.2d 493 (1974).

358. 757 S.W.2d at 414.

359. *Id.*

360. *Id.*

361. 757 S.W.2d 436 (Tex. App.—Houston [14th Dist.] 1988, no writ).

362. *Id.* at 438.

363. *Id.*

insurance policies, it has no jurisdiction to alter the designation of beneficiary.³⁶⁴ Nevertheless, the concurring justice concluded that because the husband had been subject to an injunctive order precluding the alteration of the beneficiary designation of the policy until the last business day preceding his death and because the evidence indicated that the husband had manifested his intent to alter the beneficiary, his failure to do so was no evidence of his intent that his wife should recover under the policy.³⁶⁵

VI. AGENTS

Implied or Apparent Authority. In *Lucadou v. Time Insurance Co.*³⁶⁶ the Houston court of appeals held that a summary judgment in favor of Time was erroneous because Time failed to prove conclusively that the insurance agent had no authority to bind the insurance company.³⁶⁷ Debra Lucadou alleged that the defendant's misrepresentations that she and her minor son were covered by a Time health insurance policy violated the Texas Deceptive Trade Practices Act and the Insurance Code.³⁶⁸ On January 10, 1983, Lucadou applied for health insurance and paid an initial premium to Raul G. Melchor, Time's agent, who failed to forward the application and premium to Time. After Lucadou hospitalized her son with a terminal illness, she learned she had no coverage and submitted a second application, which Time denied. Relying upon a conditional receipt, Time's literature, and Melchor's representations, Lucadou claimed that Time made misrepresentations. Lucadou's theory of recovery was supported by allegations that Melchor was Time's local recording agent or was acting with Time's express, implied, or apparent authority.³⁶⁹ In its motion for summary judgment, Time argued that because Melchor was a mere soliciting agent whose authority was limited to writing and submitting applications, it had no liability for misrepresentations. In support of its arguments, Time's evidence established only that Melchor had no actual authority because the Board had not licensed him as a local recording agent for Time and did not reach the issue of implied or apparent authority. The Houston court also determined that "upon a showing of the insured's reliance on the agent's apparent authority, even a mere soliciting agent's misrepresentations concerning health insurance coverage can render his principal vicariously liable."³⁷⁰ Failure of Time to resolve the issue of implied or apparent authority raised by Lucadou

364. *Id.* (Draughn, J., concurring).

365. *Id.* at 438-39.

366. 758 S.W.2d 886 (Tex. App.—Houston [14th Dist.] 1988, no writ).

367. *Id.* at 889.

368. See TEX. BUS. & COM. CODE ANN. § 17.50(a) (Vernon 1987); TEX. INS. CODE ANN. art. 21.21 § 4(2) (Vernon Supp. 1990).

369. The Insurance Code sets out two types of agents: local recording agents and soliciting agents. A soliciting agent's authority is more limited than a local recording agent's authority. Absent the apparent authority of a soliciting agent, only a local recording agent can bind companies on insurance risks. 758 S.W.2d at 888; see TEX. INS. CODE ANN. art. 21.14 § 2 (Vernon 1981).

370. 758 S.W.2d at 888.

precluded summary judgment for Time.³⁷¹

Time also contended that Lucadou's cause of action was barred by the two-year statute of limitation.³⁷² In its motion for summary judgment, Time contended that Lucadou's third amended petition admitted that she discovered Time's purported misrepresentation in March 1983. The Houston court of appeals disagreed, noting that the reference to the March 1983 date in the amended petition merely placed the accrual of Lucadou's fraud and misrepresentation causes of action in issue. Time, having failed to meet its burden of conclusively proving that Lucadou discovered the purported misrepresentation prior to October 21, 1983, was not entitled to summary judgment.³⁷³ Moreover, Lucadou had alleged that Time continued to misrepresent the coverage after March 1983 by reassuring that she would obtain health insurance, and Time thereby knowingly engaged in conduct solely calculated to prevent her from commencing her action against Time. The court stated that this allegation, if true, would extend the statute of limitations.³⁷⁴

In *Paramount National Life Insurance Co. v. Williams*³⁷⁵ the insured sued Paramount for breach of contract, breach of the duty of good faith and fair dealing, and fraud and violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act. Cliff Cox, an agent for Paramount, took an application for hospital insurance from Frankie Williams. Although Williams had a long history of medical problems that she described to Cox, Cox informed her that he needed to know about only the preceding five years. Paramount approved the application and issued the policy on March 20, 1981. In July 1981 and December 1981, Williams was hospitalized and thereafter filed two claims totaling over \$40,000 in connection therewith. Paramount denied the claims and cancelled the policy on the grounds that Williams had failed to disclose her full medical history on the insurance application. Williams sued.

In an attempt to show that Paramount had purposely denied the claim without reasonable investigation, Williams sought to introduce the company's actions on other similar claims. Paramount contended on appeal that such similar claims were not admissible as irrelevant to this suit. The court of appeals disagreed, holding that such claims were admissible to disclose a plan or scheme.³⁷⁶

As to Williams's breach of contract claim, Paramount argued that there was no breach of contract because of Williams's failure to disclose her pre-existing conditions. Paramount further argued that while the insurance

371. *Id.* at 889.

372. The limitation period for both causes of action is two years. *See* TEX. BUS. & COM. CODE ANN. 17.565 (Vernon 1987); TEX. INS. CODE ANN. art. 21.21 § 16(d) (Vernon Supp. 1990).

373. 758 S.W.2d at 889.

374. *Id.* at 889-90; *see* TEX. BUS. & COM. CODE ANN. § 17.565 (Vernon 1987).

375. 772 S.W.2d 255 (Tex. App.—Houston [14th Dist.] 1989, writ denied).

376. *Id.* at 259-60 (citing *Underwriters Life Ins. Co. v. Cobb*, 746 S.W.2d 810, 815 (Tex. App.—Corpus Christi 1988, no writ)).

agent acts for the carrier in delivering the policy and collecting the premiums, he acts for the insured in making the application for the insurance and in processing the policy. Furthermore, Paramount classified Cox as a soliciting agent such that he could not bind the insurance carrier by his acts and representations. The court of appeals disagreed, holding that although Cox may not have had actual authority, liability may still arise if the agent has apparent authority to act for the carrier.³⁷⁷ Such apparent authority may arise when the principal clothes the agent with the appearance of authority or fails to act to prevent the agent from appearing to have authority.³⁷⁸ The court of appeals determined that Cox acted with apparent authority on behalf of Paramount.³⁷⁹ Paramount also argued that it attempted to limit the authority of the agent by stating in the text of the application that the company was not to be bound by any knowledge or statement made by Cox unless set forth in the application. The court of appeals held that the company's actions in giving Cox its forms and referring to him as its agent contradicted the attempt to limit Cox's authority in the policy language.³⁸⁰

Paramount also argued that it did not waive its right to cancel Williams' policy, because article 21.17 of the Texas Insurance Code gave Paramount ninety days from the discovery of the falsity of the representations to give Williams notice that it was going to rescind the policy.³⁸¹ In support of its argument, Paramount contended that it did not receive Williams' hospital records until January 21, 1982. Paramount rescinded the policy on March 25, 1982. Because evidence in the record indicated that Paramount received some hospital records reflecting a diagnosis as early as August 12, 1981, the court held that Paramount had failed to meet its burden to establish as a matter of law that it rescinded the policy within the ninety-day period.³⁸²

Paramount also contended that there was no evidence that it had ever obtained knowledge of its agent's misrepresentations and that it therefore had not ratified Cox's unauthorized acts. The court of appeals noted, however, that Paramount had seen Williams' application, which provided that she was sixty-four and that she had had kidney problems and had had a cancerous uterus removed. Such information, taken in conjunction with Paramount's knowledge of the inexperience of its agent, should have put the company on notice that the potential risk required further investigation. The court of appeals held that such information was sufficient evidence of

377. *Id.* at 261.

378. *Id.*

379. *Id.* at 261-62. Oddly enough, the court of appeals went on to examine the level of education of the Williamses in examining the apparent authority of Cox. The court implied that if such a person is unable to comprehend the limit of the authority of the agent, the principal may be bound. *Id.* at 262.

380. *Id.* at 262.

381. Article 21.17 of the Texas Insurance Code provides that a defense based upon misrepresentations made in the application for insurance is not valid unless within a reasonable time after discovering the falsity, notice of the refusal to be bound is given to the insured. Ninety days is presumed to be reasonable under the statute. TEX. INS. CODE ANN. art. 21.17 (Vernon 1981).

382. 772 S.W.2d at 265.

ratification.³⁸³ In reviewing the evidence relevant to the jury's finding that Paramount was reckless in employing or retaining Cox, the court of appeals concluded that because Cox was inexperienced and relatively untrained at the time he took the application, he was unfit to take it.³⁸⁴

Paramount further questioned the award of exemplary damages as being excessive. The court of appeals determined that such damages must be in reasonable proportion to actual damages. The ratio of exemplary to actual damages in this case was one to ten. The court of appeals concluded that such an award seemed excessive in light of the harm.³⁸⁵

By crosspoint on appeal, Williams contended that the trial court erred in failing to award a twelve-percent penalty under article 3.62 of the Texas Insurance Code. Article 3.62 provides for a recovery of twelve percent on the amount of the loss if the insurance company liable for such loss fails to pay within thirty days of demand.³⁸⁶ Noting that several other courts have held that such a recovery with treble or exemplary damages is not a double recovery, and also noting that Paramount had not responded to this point of error, the court of appeals determined that such a penalty was proper.³⁸⁷

Procedure for Claiming Licensing Funds. In *Cravens, Dargan & Co. v. Peyton L. Travers Co.*³⁸⁸ the Houston court of appeals considered the application of the turnover statute to a deposit of \$25,000 filed by a local recording agent with the State Board of Insurance pursuant to the financial responsibility requirements of the Texas Insurance Code.³⁸⁹ The appellee, Travers, was a local recording agent who placed insurance risks with Cravens, a general agent, who in turn placed the risks with insurers. Pursuant to the licensing requirement of the State Board of Insurance, Travers had forwarded a cashier's check in the amount of \$25,000 payable to the State of Texas to the State Board of Insurance on March 13, 1984. The Board did not deposit the unsigned check with the State Treasury. Pursuant to the turnover statute,³⁹⁰ Cravens sought to obtain the undeposited \$25,000 check, but the trial court ordered the check deposited into the State Treasury and subsequently denied the turnover relief, holding that Cravens had to exhaust its administrative remedies before seeking relief from the courts.

Cravens argued on appeal that the requirement that property subject to the turnover statute must be within the possession or control of the judgment debtor was satisfied, claiming the State Board could not deposit the

383. *Id.* at 267.

384. *Id.* Likewise, because Paramount sponsored Cox for his license with the State Board of Insurance and made statements to the State Board of Insurance that Cox would complete a 44-hour course on insurance conducted by Paramount, which was never conducted or completed, the court held Paramount was reckless in not properly preparing Cox to sell its insurance. *Id.*

385. *Id.* at 268. The court concluded that if Williams filed a remittitur of \$250,000 within 15 days, the judgment would be reformed and affirmed; otherwise the judgment would be reversed and remanded.

386. TEX. INS. CODE ANN. art. 3.62 (Vernon 1981).

387. 772 S.W.2d at 270.

388. 770 S.W.2d 573 (Tex. App.—Houston [1st Dist.] 1989, writ denied).

389. TEX. INS. CODE ANN. art. 21.14, § 3(c)(3)(c) (Vernon Supp. 1990).

390. TEX. CIV. PRAC. & REM. CODE ANN. § 31.00& (Vernon 1986).

funds without Travers' signature and therefore they were in his control. The appellate court rejected this argument, holding that Travers' ownership rights to the \$25,000 terminated when Travers tendered the funds to the appellee.³⁹¹

The Houston court of appeals further held that the turnover statute was purely procedural in nature and thus did not provide for the determination of the substantive rights of the parties.³⁹² Cravens could not use the turnover statute as a means of determining the ownership of the funds deposited with the State Board of Insurance.³⁹³ Instead, the appeals court indicated that Cravens must first petition the Board to release the deposit.³⁹⁴ If the right to those funds is contested, the proper procedure to determine the ownership of the deposit is an administrative hearing,³⁹⁵ as provided in the Administrative Procedure and Texas Register Act.³⁹⁶ Cravens could seek judicial review only after an adverse decision in the administrative proceeding.³⁹⁷

Duty to Inform. In *Shindler v. Mid-Continent Life Insurance Co.*³⁹⁸ the Houston court of appeals held that an agent has no duty to give notice to the insured of overdue payments on a life insurance policy.³⁹⁹ In May 1980 James Shindler bought two life insurance policies from Mid-Continent Life Insurance Company, through Mid-Continent's agent, Compensation Systems, Inc. The two policies provided that the failure to pay the required annual premium within thirty days of the due date would result in the expiration of the policy. Shindler paid the initial premiums, but subsequently paid no annual premiums, and the policies expired in May 1981. In March 1984, when Shindler discovered he had cancer, he also learned of the expirations. Shindler demanded reinstatement of the policies. When Mid-Continent refused, Shindler brought suit against Mid-Continent and Compensation Systems, Inc., alleging a breach of the duty to inform of premiums due and of policy cancellation. Shindler also sued for misrepresentations, alleging that through various correspondences, Mid-Continent and Compensation represented that the policies were still in effect.

The Houston court of appeals held that, absent policy provisions to the contrary, an insurer has no legal duty to give notice of premiums due or to give notice that a policy has lapsed.⁴⁰⁰ While recognizing that the agent itself might have a duty to inform the insured when the agent receives notice of premiums due, the Houston court determined that Shindler had failed to raise a fact issue concerning Compensation's receipt of notice of the overdue

391. 770 S.W.2d at 576.

392. *Id.*

393. *Id.* at 576-77.

394. *Id.* at 577.

395. *Id.*

396. *See* TEX. REV. CIV. STAT. ANN. art. 6252-13a (Vernon Supp. 1990).

397. 770 S.W.2d at 577.

398. 768 S.W.2d 331 (Tex. App.—Houston [14th Dist.] 1989, no writ).

399. *Id.* at 333-34.

400. *Id.* at 333.

payment from the insurer.⁴⁰¹

With regard to misrepresentation, the evidence showed that Mid-Continent acknowledged receipt of Shindler's requested changes of the ownership and beneficiary designation on the two policies in the fall of 1981 and that Shindler had received an analysis of coverage from Compensation in March of 1983 that included the two life insurance policies. Shindler contended that these actions amounted to a misrepresentation under article 21.21 of the Texas Insurance Code that the insurance was still in effect. The court of appeals acknowledged that such correspondence could be misleading, but it held that Shindler was charged with the knowledge that the two policies terminated by their own terms in May 1981 for nonpayment of premiums because an insured is deemed to know the contents of the contract he makes.⁴⁰² The court also held that Shindler could not assert a claim for misrepresentation based on conduct occurring after the policies had terminated due to nonpayment of premiums.⁴⁰³

VII. MISCELLANEOUS CASES

Notice of Cancellation. If a policy provides for constructive notice of cancellation upon mailing, whether the insured receives notification is immaterial to the validity of the cancellation.⁴⁰⁴ Evidence that the insured never received notification, however, is relevant to prove that the notice may have never been mailed.⁴⁰⁵ In *Har-Con Corp. v. Aetna Casualty & Surety Co.*⁴⁰⁶ a majority of the court of appeals ruled that the denial of receipt by an officer of a corporate insured was sufficient to present a fact question as to whether the insurer ever mailed the notice, even though the insurer tendered a signed return receipt card and supporting affidavit indicating that the notice had been mailed.⁴⁰⁷ The majority reasoned that, because the affidavit of one officer of a corporate insured stated that it was based on personal knowledge and that the corporation had never received the notice, the insurer failed to establish conclusively the fact that the notice had been mailed.⁴⁰⁸

Burden of Producing Policy: Insurer Versus Third-Party Beneficiary. In suits

401. The Houston court arrived at this conclusion despite testimony from an employee of the insurer that to the best of her knowledge Compensation received notice of late payment and lapse of the policy. *Id.* at 334.

402. *Id.* at 334-35.

403. *Id.* at 335.

404. See *Sudduth v. Commonwealth County Mut. Ins. Co.*, 454 S.W.2d 196, 196 (Tex. 1970); *American Casualty Co. v. Conn.*, 741 S.W.2d 536, 540 (Tex. App.—Austin 1987, no writ).

405. *Sudduth*, 454 S.W.2d at 197.

406. 757 S.W.2d 153 (Tex. App.—Houston [1st Dist.] 1988, no writ).

407. *Id.* at 156.

408. *Id.* As Justice Duggan pointed out in his dissent, the flaw in the reasoning of the majority was its acceptance of the officer's statement as true that he had personal knowledge that the corporation had not received the notice of cancellation. *Id.* Nothing in the affidavit showed that no other officer or agent of the corporation existed who could have received the notice. In the absence of such a showing, it would have been impossible for the testifying officer to have personal knowledge of whether any other agent for the corporation could have received the notice. Cf. *Jimmy Swaggart Ministries v. City of Arlington*, 718 S.W.2d 83, 86 (Tex. App.—Fort Worth 1986, no writ) (denial of receipt by some, but not all, agents of a

involving insurance contracts, the insurer, as holder of the policy, has the burden of producing the policy in the event of a dispute over its contents.⁴⁰⁹ In *Paragon Sales Co. v. New Hampshire Insurance Co.*⁴¹⁰ the supreme court imposed the same burden on the insurers when a third-party beneficiary sued to recover policy benefits.⁴¹¹ Once a third party establishes its standing to recover under the contract, the insurer must plead and prove the provisions of the insurance contract that differ from those alleged or that bar all or part of the claimant's recovery.⁴¹²

Disqualification of Insurer's Former Counsel. In *NCNB Texas National Bank v. Coker*⁴¹³ an insurer sought to disqualify counsel for the insured in suits concerning policies guaranteeing the payment of equipment leases. The insurer contended that a conflict of interest disqualified the insured's counsel because the same law firm had previously represented the insurer in an earlier suit concerning the termination of reinsurance treaties. The insurer alleged that during the course of that litigation, counsel learned confidential information about the insurer. The supreme court held that the attorneys could not be disqualified unless the matter in which they represented the insurer was substantially related to the current litigation between the insurer and the insured to the degree that a genuine threat that counsel might disclose the confidential information existed.⁴¹⁴ The court further concluded that unless the circumstances reflecting a substantial relationship between the subject of the former litigation and the pending litigation were specifically recited, the trial court's order disqualifying counsel would be deemed an abuse of discretion.⁴¹⁵

Administrative Law. To obtain an agent's license, a corporation is required first to deposit \$25,000 in cash or securities with the state treasurer.⁴¹⁶ The deposit may not be returned to the corporate agent unless it either withdraws from the business of insurance with no unsecured outstanding liabilities or demonstrates that it is covered under either an errors and omissions policy or a bond for the protection of its customers.⁴¹⁷ In *Cravens, Dargan & Co. v. Travers Co.*⁴¹⁸ the State Board of Insurance issued a license to the corporate agent after it tendered a cashier's check for \$25,000 as proof of financial responsibility. The Board, however, did not immediately deposit the check with the state treasurer. In the interim, judgment was rendered against the agent, and pursuant to the "turnover" statute,⁴¹⁹ the judgment creditors sought to recover the check from the Board on the theory that it

professional corporation who regularly handle mail addressed to the corporation did not rebut the presumption that an item deposited in the mail was delivered as addressed).

409. *McConnell Constr. Co. v. Insurance Co.*, 428 S.W.2d 659, 662 (Tex. 1968).

410. 774 S.W.2d 659 (Tex. 1989).

411. *Id.* at 661.

412. *Id.*

413. 765 S.W.2d 398 (Tex. 1989).

414. *Id.* at 400.

415. *Id.*

416. TEX. INS. CODE ANN. art. 21.14, § 3(c)(3) (Vernon Supp. 1990).

417. *Id.*

418. 770 S.W.2d 573 (Tex. App.—Houston [1st Dist.] 1989, writ denied).

419. TEX. CIV. PRAC. & REM. CODE ANN. § 31.002 (Vernon 1986).

remained under the agent's control until the agent endorsed a form authorizing deposit with the state treasurer. The court of appeals rejected this claim, reasoning that the corporate agent surrendered control of the funds when it tendered the check to the State Board of Insurance.⁴²⁰ Noting that the turnover statute neither altered substantive legal rights nor applied to property not controlled by the judgment debtor, the court concluded that the check could only be released after administrative proceedings before the Board.⁴²¹

When the results of administrative proceedings such as those suggested in *Travers* are unsatisfactory, the complaining party may perfect an appeal to the district court.⁴²² To appeal the order of an agency to a district court, the complaining party must file a motion for rehearing within fifteen days after the agency renders its final order.⁴²³ The manner in which that appeal must be perfected was the subject of inquiry in *Commercial Life Insurance Co. v. Texas State Board of Insurance*⁴²⁴ and *Ross v. Texas Catastrophe Property Insurance Association*.⁴²⁵

In *Commercial Life* an insurance company sought to appeal the order of the State Board of Insurance denying its application to use a particular trade name. Because the agency never sent the insurer notice of the rendition of its order, the insurer failed to timely file its motion for rehearing, and the district court dismissed its appeal for want of jurisdiction. The insurer appealed, urging that the time to file a motion for rehearing did not start running until the agency notified the complaining party of its final action. Relying on its earlier decisions in *Leisure Services v. Texas Catastrophe Property Insurance Association*⁴²⁶ and *Navarro Independent School District v. Brockette*,⁴²⁷ the court of appeals held that nothing in the statute permitting administrative appeals authorized an extension of time to perfect the appeal even when the agency failed to provide notice of the rendition of a final order.⁴²⁸ Likewise, the court rejected the insurer's argument that the district court's dismissal of its appeal unconstitutionally deprived the insurer of its property right to use a particular trade name.⁴²⁹ The court reasoned that

420. *Id.* at 576.

421. *Id.* at 576-77.

422. See TEX. REV. CIV. STAT. ANN. art. 6252-13a (Vernon Supp. 1990).

423. Section 16(e) of the Administrative Procedure and Texas Register Act provides: "[A] motion for rehearing is a prerequisite to an appeal. A motion for rehearing must be filed by a party within 20 days after the date the party or his attorney of record is notified of the final decision or order . . ." TEX. REV. CIV. STAT. ANN. art. 6252-13a, § 16(e) (Vernon Supp. 1990); see also *Vandergriff v. First Fed. Sav. & Loan Ass'n*, 586 S.W.2d 841, 842 (Tex. 1979) (motion for rehearing on decisions by Texas Savings and Loan Commission is jurisdictional prerequisite to filing suit in district court); *Leisure Serv. v. Texas Catastrophe Property Ins. Ass'n*, 712 S.W.2d 266 (Tex. App.—Austin 1986, writ ref'd n.r.e.) (motion for rehearing within 15 days after rendition of order is required to appeal decisions of State Board of Insurance).

424. 756 S.W.2d 859 (Tex. App.—Austin 1988), *rev'd*, 774 S.W.2d 650 (Tex. 1989).

425. 770 S.W.2d 641 (Tex. App.—Austin 1989, no writ).

426. 712 at 268 (disapproved in *Commercial Life Ins. Co. v. State Board of Ins.*, 774 S.W.2d at 652).

427. 566 S.W.2d 699, 701 (Tex. Civ. App.—Austin 1978, no writ) (disapproved in *Commercial Life Ins. Co. v. State Board of Ins.*, 774 S.W.2d at 652).

428. 756 S.W.2d at 860-61.

429. *Id.* at 861.

the insurer had no legitimate entitlement to the use of any particular trade name because a property right exists only when there is a legitimate claim of entitlement rather than an abstract need, desire, or unilateral expectation.⁴³⁰

In reviewing this decision, the supreme court found it unnecessary to decide the insurer's due process claim because it disagreed with the reasoning of the court of appeals on the question of whether the agency's failure to notify the insurer excused the untimely filing of an appellant's motion for rehearing.⁴³¹ The basis of its disagreement was the provision of the version of section 16(b) of the Administrative Procedure and Texas Register Act⁴³² then in effect that required the agency to notify the parties of its order "either personally or by mail."⁴³³ The supreme court concluded that by including this requirement, the statute made notice an implicit part of the act of rendition without which the expiration of the time for moving for rehearing may not commence.⁴³⁴ This decision is limited, however, to the perfection of appeals from orders rendered before September 1, 1989.⁴³⁵

In *Ross* the insured filed its motion for rehearing with the State Board of Insurance *after* the hearing examiner made a recommendation to the Board concerning the disposition of the insured's claim but *before* the Board entered its final order. In an appeal from the district court's dismissal of her appeal for want of jurisdiction, the insured urged that a motion for rehearing filed before the Board rendered its final order, although premature, was nevertheless adequate to perfect the administrative appeal. In support of this contention, the insured relied on *El Paso Electric Co. v. Public Utility Commission*,⁴³⁶ in which a motion for rehearing filed after an administrative agency announced its ruling on the record but before the issuance of a writ-

430. *Id.*

431. 774 S.W.2d at 652.

432. TEX. REV. CIV. STAT. ANN. art. 6252-13a, § 16(b) (Vernon Supp. 1990).

433. 774 S.W.2d at 651-52; *see* TEX. REV. CIV. STAT. ANN. art. 6252-13a, § 16(b) (Vernon Supp. 1990).

434. 774 S.W.2d at 652.

435. *Id.*; *see* Act of June 14, 1989, ch. 362, § 3, 1989 TEX. SESS. LAW SERV. 1448 (Vernon). Thereafter the time for filing a motion for rehearing will be governed by the amendments to section 16(b) adopted by the 71st Legislature. As amended, it provides:

b) A final decision must include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, must be accompanied by a concise and explicit statement of the underlying facts supporting the findings. If, in accordance with agency rules, a party submitted proposed findings of fact, the decision shall include a ruling on each proposed finding. Parties shall be notified either personally or by first class mail of any decision or order. When an agency issues a final decision or order ruling on a motion for rehearing, the agency shall send a copy of that final decision or order by first class mail to the attorneys of record and shall keep an appropriate record of that mailing. If a party is not represented by an attorney of record, then the agency shall send a copy of a final decision or order ruling on a motion for rehearing by first class mail to that party, and the agency shall keep an appropriate record of that mailing. A party or attorney of record notified by mail of a final decision or order as required by this section shall be presumed to have been notified on the date such notice is mailed.

TEX. REV. CIV. STAT. ANN. art 6252-13a, § 16(b) (Vernon Supp. 1990).

436. 715 S.W.2d 734 (Tex. App.—Austin 1986, writ ref'd n.r.e.).

ten order was held sufficient to perfect the right to appeal.⁴³⁷ The court of appeals rejected this contention and affirmed the trial court's dismissal.⁴³⁸ The court noted that the distinction between *Ross* and *El Paso Electric* was the fact that section 16(a) of the Administrative Procedures and Texas Register Act⁴³⁹ provided that the agency's announcement of its ruling may be either in writing or stated verbally on the record and that the motion for rehearing in *El Paso Electric* was deemed to be timely because it was filed after the agency announced its decision on the record.⁴⁴⁰

Administrative Proceedings as Evidence of Bad Faith. The court in *Paramount National Life Insurance Co. v. Williams*⁴⁴¹ enhanced the importance of a comprehensive understanding of procedures before the State Board of Insurance. Following the reasoning of *Aztec Life Insurance Co. v. Dellana*,⁴⁴² the court in *Paramount National* held that complaints to the State Board of Insurance regarding an insurer's disposition of the claims of other insureds were admissible provided the jury was instructed that the evidence should be considered not to determine the truth, but to aid in the determination of whether the insurer has a custom of denying claims based on certain policy exclusions.⁴⁴³ The court reasoned that evidence of administrative proceedings before the State Board of Insurance regarding the denial of other claims on a similar basis were relevant to the question in bad faith cases of whether the denial of the claim was part of a larger plan or scheme.⁴⁴⁴

Arbitration and Article 21.21. The Federal Arbitration Act provides that "[a] party aggrieved by the alleged failure . . . of another to arbitrate under a written agreement may petition any United States district court . . . for an order directing that such arbitration proceed . . ."⁴⁴⁵ The parties in *Triton Lines v. S.S. Mutual Underwriting Association*⁴⁴⁶ entered into an agreement to insure the *M.V. Triton Trader* that required arbitration of disputes under the agreement. After the loss of the insured vessel, the insured refused to arbitrate its claim and instead sued in federal district court under Texas law, alleging violation of the consumer protection provisions of the Texas Insurance Code.⁴⁴⁷

The insurer moved to stay the action until the insured's claims could be subjected to arbitration. The insured argued that the Federal Arbitration Act⁴⁴⁸ did not apply because arbitration would impair the enforcement of

437. *Id.* at 738.

438. 770 S.W.2d at 644.

439. TEX. REV. CIV. STAT. ANN. art. 6252-13a, § 16(a) (Vernon Supp. 1990).

440. 770 S.W.2d at 644.

441. 772 S.W.2d 255 (Tex. App.—Houston [14th Dist.] 1989, writ requested).

442. 667 S.W.2d 911, 915 (Tex. App.—Austin 1984, no writ) (nothing bars admission of evidence in bad faith suit indicating that insurer consistently denied claims on basis of exclusion without reasonably investigating claim).

443. 772 S.W.2d at 259-60.

444. *Id.* at 260.

445. 9 U.S.C. § 4 (1983).

446. 707 F. Supp. 277 (S.D. Tex. 1989).

447. See generally TEX. INS. CODE ANN. art. 21.21 (Vernon 1981 & Vernon Supp. 1990).

448. 9 U.S.C. § 4 (1988).

state laws regulating the business of insurance,⁴⁴⁹ which the McCarran-Ferguson Act expressly provided that “[n]o Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance”⁴⁵⁰ The federal district court rejected this contention because it determined that article 21.21 was not a statute “regulating the business of insurance.”⁴⁵¹ The court reasoned that for purposes of the McCarran-Ferguson Act, the “business of insurance” included the underwriting and spreading of the insured’s risk, but not the resolution of disputed claims.⁴⁵² Further, the court noted that the McCarran-Ferguson Act did not abrogate federal procedural statutes and that the Federal Arbitration Act was procedural in nature.⁴⁵³

Title Insurance. In *First National Bank v. Associated Attorneys Title Agency, Inc.*⁴⁵⁴ a bank loaned \$125,000 on property that a title insurance company had represented to be owned by a corporation. The loan was secured by a nonrecourse mortgage. The evidence showed, however, that the mortgaged property was not owned by the debtor corporation but rather by an officer in the corporation. Although the title insurance company never issued a policy, the bank sued the company after the borrower defaulted on the note. The bank alleged that the company was liable for the bank’s damages because it negligently supplied information that resulted in the bank’s failure to perfect a valid lien on the property. The jury found that although the title company was negligent, the bank’s loss was not caused by the title company’s negligence. On appeal, the bank urged that no evidence supported this finding. Nevertheless, the court of appeals affirmed because the commitment to provide title insurance expired before the bank consummated the loan and because the commitment expressly notified the bank that the title company would not be liable for title defects unless a policy was issued before the commitment expired.⁴⁵⁵

The question presented in *Stewart Title Guaranty Co. v. Cheatham*⁴⁵⁶ was whether a title insurance company would be liable not only under its policy but also under the Deceptive Trade Practices Act if it issued a title insurance policy but failed to ascertain a defect in the insured’s title. The insured in *Cheatham* alleged that the failure of the policy to reveal the existence of a utility easement constituted a deceptive trade practice in light of the policy’s recitation that the insurer guaranteed that the insured had good and indefeasible title. The court of appeals and the insurer agreed that it was liable

449. *Id.* at 277-78.

450. 15 U.S.C. § 1012(b) (1982).

451. 707 F. Supp. at 279.

452. *Id.*; see also *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221 (1979) (business of insurance involves underwriting of risks and relationship and transactions between insurance companies and their policy holders).

453. 707 F. Supp. at 279; see also *Life Ins. Co. of Am. v. Aetna Life Ins. Co.*, 744 F.2d 409, 413 (5th Cir. 1984) (in action for treble damages, enforcement of arbitration agreement did not impair Texas insurance law even though arbitrator could not award treble damages).

454. 759 S.W.2d 481 (Tex. App.—Waco 1988, no writ).

455. *Id.* at 483. The court addressed the question as one of causation. In the authors’ view, the court opinion addresses the element of duty more than causation.

456. 764 S.W.2d 315, 317 (Tex. App.—Texarkana 1988, writ denied).

under the policy; the court concluded, however, that the insurer was not liable under the DTPA.⁴⁵⁷ The court reasoned that, because the guaranty provision on which the insurer relied appeared in the context of a contract to *indemnify* the insured, it did not also obligate the insurer to perform an examination of title for the insured.⁴⁵⁸ The court held that the insured could not rely on the results of the insurer's examination because it was performed solely to aid the insurer in its determination to issue a policy.⁴⁵⁹ Finding no evidence of any extra-contractual representation concerning the validity of the insured's title, the court held that the insured was entitled to recover only under the terms of the title insurance policy and not under the DTPA.⁴⁶⁰

In contrast with *Stewart Title, Transamerica Title Insurance Co. v. San Benito Bank & Trust Co.*⁴⁶¹ involved a claim of deceptive acts and practices by a title insurer concerning the handling of a claim rather than the title insurer's failure to note an encumbrance. In *Transamerica* the insured bank loaned \$500,000 secured by what the bank believed from the title policy to be a lien that was subordinate only to a first lien securing another \$500,000 debt. In fact, the bank's lien was also subordinate to a second lien securing a debt of approximately \$1,200,000. Its omission from the policy exceptions was discovered after the creditor posted the property for foreclosure.

Rather than paying its \$500,000 policy limits, the insurer offered the insured \$100,000 in settlement of the claim, which the insurer had valued at \$130,000. When the insured rejected this offer, the insurer sought to put the insured in the position in which it would have been but for the omission of the second lien. Through negotiations with the second lienholder, the insurer acquired the second lienholder's position for \$100,000. The insurer, however, also allowed the former second lienholder to acquire the first lienholder's position. While these negotiations made the insured a second lienholder, its lien was now subordinate to a lien securing a much larger debt than anticipated. When the first lienholder foreclosed, the insured was left with a lien that was worthless. The insured sued for bad faith, and the jury imposed over \$400,000 actual and \$1.8 million punitive damages upon the insurer.

On appeal, the insurer first urged that it owed the insured no contractual duty to negotiate a settlement in good faith because the insured had suffered no loss until after the negotiations were concluded. The court of appeals rejected this contention and held that, when the title insurer voluntarily engaged in settlement negotiations, it was obligated to exercise reasonable care for the insured's interest.⁴⁶² The court further concluded that evidence that the insurer knowingly obtained a second lien position for the insured that

457. *Id.* at 318-19.

458. *Id.* at 319.

459. *Id.*

460. *Id.* at 320-21.

461. 756 S.W.2d 772 (Tex. App.—Corpus Christi 1988), *vacated by agr.*, 773 S.W.2d 13 (Tex. 1989).

462. 756 S.W.2d at 775-76.

was likely to be worthless and attempted to settle with the insured at less than the insurer's own estimated value of the claim was sufficient to support the jury's findings of negligence and bad faith.⁴⁶³ The court of appeals next examined the evidence to support the jury's award of punitive damages and found it sufficient under the circumstances of the case.⁴⁶⁴

463. *Id.* at 776.

464. *Id.* at 776-77.